

2014

Toward a Public Health Legal Structure for Child Welfare

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Recommended Citation

Joshua Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897 (2014).
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Toward a Public Health Legal Structure for Child Welfare

ABSTRACT

The present American child welfare system infringes upon the fundamental liberty interests of millions of children and parents, is adversarial and punitive, and fails to prevent child maltreatment or protect children adequately from its most severe forms. Many in the field now recognize that a public health model would more effectively support the parent-child relationship and protect children from maltreatment than the current paradigm. Despite much attention to such an approach, the field has yet to develop a clear vision for how the law could or should support a public health approach or shape the actions of individuals and institutions best suited to lead a public health response. This Article is the first to identify the core legal reforms necessary to shape a public health approach to child welfare.

This Article identifies several legal pillars of the present parental-fault paradigm that impede a public health approach and conceptualizes new laws designed to foster a public health approach. First, mandatory reporting and mandatory investigation laws—requiring professionals to report and child protection agencies to investigate all instances of suspected neglect—inhibit a public health response by imposing a coercive legal regime on an overly broad category of cases and preventing professionals from making more effective interventions for millions of children.

Second, state laws' overly broad definitions of "abuse" and "neglect" expand the range of situations subject to mandatory reporting and mandatory investigations laws and permit coercive interventions to become the dominant means of responding to serious child welfare problems.

Third, the law should separate provision of services to children and families from findings of fault by CPS agencies. In the aggregate, fam-

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ilies involved with CPS agencies have relatively high levels of need and would benefit from services provided as soon as possible. Yet CPS agencies tie services to findings of fault, denying services to many families.

Fourth, federal funding law should cease preferred treatment of foster care and permit greater flexibility to provide a full spectrum of interventions.

Fifth, the law should identify institutions, such as schools, hospitals, and doctors, poised to implement a public health approach and should develop legal reforms to push those institutions to do so.

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I. INTRODUCTION

The present American child welfare system follows a parental-fault paradigm: the system uses legal power to identify and prove bad parenting, then protect children from its consequences. Essential decisions focus on individual events of alleged parental misconduct

rather than the full context of children's and parents' lives and needs. The law has given this system a tremendously wide scope—whenever there is reasonable suspicion that some parental fault exists, broadly defined, the law triggers coercive state power. The result is a system that infringes upon the fundamental liberty interests of millions of children and parents, costs billions of dollars, is adversarial and punitive, and fails to prevent child maltreatment or protect children adequately from its most severe forms.

Many in the field now recognize that a public health model would provide a more effective means of supporting the parent–child relationship and protecting children from maltreatment than the current paradigm. A public health approach would provide a wider range of interventions to achieve the goal of preventing future maltreatment more effectively. It would label parental fault only when coercive state intervention is necessary to protect children and when less invasive alternatives will not work or have not worked. It would respond to children's evident needs by considering them in their full context—which scholars have rightly identified as crucial to a truly child-centered approach¹—and providing services without waiting to determine parental fault first. Such an approach would better account for the competing constitutional values at stake in child welfare—seeking the most effective protection for children and assistance to families while minimizing government coercion, invasions of core liberty interests, and sanctions.

Still, the field has yet to develop a clear vision for how the law could support a public health approach or shape the actions of individuals and institutions best suited to lead a public health response. This Article seeks to fill that void and identify the core legal reforms necessary to shape a public health approach to child welfare. It identifies several legal pillars of the present parental-fault paradigm that impede a public health approach and conceptualizes new laws designed to foster a public health approach across a range of entities.

First, a set of laws that have structured the existing American child protection system—in particular, mandatory reporting and mandatory investigation laws—inhibit a public health response by imposing a coercive legal regime on an overly broad category of cases.² When a professional is concerned about a family, the law directs that professional to call in the concern to child protection agencies and instructs those agencies to investigate whether a parent is at fault. Mandatory reporting statutes have become canonical in the United States, but other developed countries protect children without them. Child welfare experts from competing perspectives have offered robust

1. *Infra* notes 166–67 and accompanying text.

2. *Infra* Part III.

criticisms of these laws, which overwhelm child protective services (CPS)³ agencies with large numbers of relatively minor allegations and make it harder for those agencies to protect children from the most severe maltreatment.⁴ A public health perspective adds a new critique: many mandatory reporters are best suited to coordinate a public health response for the more than three million American children annually reported to CPS agencies,⁵ but they do not do so because mandatory reporting laws instruct them to call CPS and then let CPS handle the situation.

Mandatory investigation statutes—which require CPS agencies to investigate every allegation of child abuse or neglect—cause CPS agencies to invade the privacy of children and parents through coercive and adversarial investigations. Scholars have begun to recognize how these investigations violate children’s and parents’ Fourth Amendment rights and are themselves harmful to children.⁶ When these investigations lead agencies to determine that a parent has neglected a child, agencies then place parents’ names on child protection registries. This sanction often succeeds only in limiting parents’ job prospects and thus their children’s economic futures. Perhaps most importantly, mandatory CPS investigations have been shown to miss opportunities to prevent child abuse or neglect because they try to find parental fault, not provide effective interventions.⁷

Although mandatory investigations remain the norm, they have begun to fall into disfavor, as a growing number of CPS agencies apply “differential response” approaches. These agencies triage less severe allegations and offer voluntary services to affected families without an investigation and without placing parents on a registry. Child protection investigators are then freed to focus on more severe allegations and can more effectively protect children from the worst forms of abuse and neglect. While a significant step forward, differential response involves implicit warnings that CPS will impose sanctions on families that do not comply with services, a level of coercion that may be unnecessary. It still centralizes interventions in CPS agencies, without fully involving individuals and institutions best suited to provide a public health response.

Second, state laws’ definition of “abuse” and “neglect” is quite broad, granting agencies and courts wide authority to intervene coer-

3. Child protective services (CPS) refers to the state and local agencies that, despite various names in different jurisdictions, are similarly charged with investigating child abuse and neglect allegations, determining whether to remove children from their families, and operating a foster care system.

4. *Infra* section III.A.

5. *Infra* note 56 and accompanying text.

6. *Infra* note 82.

7. *Infra* notes 112–20 and accompanying text.

cively in families whenever a parent provides inadequate care.⁸ Under the present system, such broad definitions expand the range of situations subject to mandatory reporting and mandatory investigations laws, thus increasing the harms just described by a significant order of magnitude. Broad definitions of abuse and neglect, coupled with broad discretion given to CPS agencies and family court judges to seek or impose dispositions that they think best, leads to a remarkably inconsistent set of practices, in which some children are not protected enough and other children are removed from their families unnecessarily. Beyond the absence of equity, the resulting inconsistent practice deprives researchers and policy makers of the shared definitions of abuse and neglect necessary to develop public health tools, such as statistically valid risk assessments to determine which children are in greatest need of protection.

Third, the law should separate provision of services to children and families from CPS agencies' findings of fault. In the aggregate, families that come into contact with CPS agencies have relatively high levels of need and would benefit from services provided as soon as possible, regardless of whether the abuse is substantiated. Yet, in practice, CPS agencies tie services to substantiation. Some laws even permit agencies to take custody of children for the purposes of providing certain expensive services, rather than simply providing those services directly to children and families.⁹ A public health approach would seek to provide services whenever they make sense, without regard to substantiation of a particular allegation. Legal reforms can direct CPS agencies to provide services whenever they are indicated—even before completion of an investigation—to ensure families never have to lose custody of their children to obtain services for them.

Fourth, federal funding laws should cease their preferred financial treatment of foster care—the most invasive child welfare intervention.¹⁰ Current federal law provides more generous funding for foster care services than for services to help children remain safe in their families' custody. A public health approach would permit greater flexibility to states so that they can provide a full spectrum of interventions to families.

Fifth, the law should identify institutions poised to implement a public health approach and develop legal reforms to push those institutions to implement a public health response. Primary and secondary schools present an apt example. Their personnel account for the largest source of reports to child abuse and neglect hotlines and are

8. *Infra* Part IV.

9. This scenario most often occurs to place children in state-funded psychiatric residential treatment facilities or similarly intensive mental health services. *Infra* notes 276–77 and accompanying text.

10. *Infra* Part VI.

among those best suited to arrange a public health response because they are familiar with children in their full context, including their families, peer groups, and communities. Yet when faced with a child experiencing some form of maltreatment and the behavioral and academic consequences of it, schools typically focus on a limited range of services for children or respond punitively to children when maltreatment leads to bad behavior. The law should structure schools to provide a public health response. District, state, and federal education authorities should create standards for when and how school staff attempts to identify helpful services for families. State and local governments should create legal ties between schools and other health and social service agencies. When school officials cannot accomplish what they want for a child, the law should give them options other than calling CPS. For instance, states could create public health hotlines or voluntary community family services programs in which any mandatory reporter could call in-service providers better equipped to provide the necessary assistance.

Pregnant and postpartum women who abuse drugs present another example of the problem with mandatory reporter laws for hospitals and doctors. Most debates have focused on how to determine which women to test for substance use and which to report to CPS authorities. This practice leaves the majority of families affected by such substance use unidentified and, for a small portion of families, triggers a particularly invasive form of intervention with little evidentiary support. A public health approach could improve identification of families facing this serious health issue and the likelihood of a more effective treatment, rather than a CPS response. It would require greater linkages between doctors and hospitals that are in positions to identify families facing this problem, as well effective treatment facilities both for pregnant women and postpartum women. Facilities that permit postpartum women to live with their children are necessary, as are services to address any developmental needs that substance-exposed children may have. Professionals would continue to frequently see women with substance-abuse problems and their children and call CPS authorities when circumstances suggest a risk of near term harm to the child or suggest that a coercive approach is necessary.

In the contested field of child welfare, some may read this Article's proposals to determine if they seek to expand state intervention to protect children by increasing removals to foster care or if they seek to limit such removals. The answer is neither. The present foster care system is both over- and under-broad, and a public health approach would seek to keep some families presently in foster care out of that coercive system while better identifying other families whose children need the protection of that system.

This Article proceeds as follows. Part I summarizes the existing parental-fault paradigm and contrasts it with a public health approach. Part I also explains the shortcomings of the present paradigm—the children left unprotected from serious harm, the children unnecessarily separated from their families, and the hundreds of thousands, if not millions, of children and families with some serious and treatable problems who fail to benefit from present CPS interventions. Part II identifies two pillars of the present system that impede development of a public health approach—mandatory reporting and mandatory investigation laws, which legally mandate an invasive, coercive, and stigmatizing governmental response to a much wider set of cases than call for such action. Part III discusses the overly broad definitions of abuse and neglect and the absence of clear legal guidelines for dispositions of children once parental abuse or neglect is found. Part IV argues that law reform is necessary to separate the provision of or referrals to services by child protection agencies from findings of parental fault. Part V argues for reforming federal child welfare financing to permit more flexibility for states to develop public health approaches. Part VI discusses new laws that can help catalyze a public health approach, especially in public schools and with medical professionals who serve pregnant and postpartum women who abuse drugs.

II. PARENTAL FAULT, PUBLIC HEALTH, AND THE PRESENT CHILD WELFARE SYSTEM'S FAILURES

A. Parental-Fault Paradigm

The present system centers on legal findings of parental faults, not children's needs.¹¹ The system only intervenes in a family if the state can prove that a parent has abused or neglected a child. Parental fault is jurisdictional; without it, there are no legal grounds for the court system to intervene or for a child protection agency to force a family to work with it.¹² Child protection agencies investigate whether children or families have particular needs, but whether a parent has done something wrong to endanger the child. As Gary

11. See Barbara Bennett Woodhouse, *Ecogenerism: An Environmentalist Approach to Protecting Endangered Children*, 12 VA. J. SOC. POL'Y & L. 409, 423 (2005) (explaining that because any state intervention that limits family autonomy violates rights, "the model depends on parental fault as a predicate for state engagement in the life of the child").

12. The Supreme Court has held that parents are "entitled to a hearing on [their] fitness as a parent before" the state may remove children from their custody. *Stanley v. Illinois*, 405 U.S. 645, 649 (1972). If the state cannot prove that a parent has abused or neglected a child—constitutionally, that a parent is unfit—then the court must dismiss the case and lacks authority to intervene in the family. *E.g.*, D.C. CODE § 16-2317(b).

Melton has put it, “By law, social workers’ time is focused first and foremost on the question of ‘What happened?’, not ‘What can we do to help?’”¹³ CPS investigations thus have, in the federal government’s term, an “adversarial orientation.”¹⁴

This parental fault focus permeates the entire system. C. Henry Kempe’s seminal 1962 medical paper, “The Battered-Child Syndrome,” expressed some sympathy for child abusers as individuals suffering from some serious disorder¹⁵ but nonetheless identified “a small deviant ‘other’” that society could fairly condemn.¹⁶ The child welfare system that developed following his influential paper assumes that the children it impacts are endangered by a parent’s “moral, psychological, physiological, or some other personal failing,”¹⁷ even if the system developed a scope far beyond the severe abuse cases that Kempe described.¹⁸ Accordingly, the system’s “master narrative” is one of children victimized by deviant or degenerate parents¹⁹ and thus in need of coercive state protection.²⁰ Social science literature has

13. Gary B. Melton, *Mandatory Reporting: A Policy Without Reason*, 29 CHILD ABUSE & NEGLECT 9, 14 (2005).

14. U.S. DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES, DIFFERENTIAL RESPONSE TO REPORTS OF CHILD ABUSE AND NEGLECT 6, (2008), available at http://www.childwelfare.gov/pubs/issue_briefs/differential_response/differential_response.pdf. [hereinafter DIFFERENTIAL RESPONSE]. See also HARVEY SCHWEITZER & JUDITH LARSEN, FOSTER CARE LAW: A PRIMER 65 (2005) (explaining that child protection investigation “is most often adversarial rather than cooperative”).

15. C. Henry Kempe et al., *The Battered-Child Syndrome*, 181 J. AM. MED. ASS’N 17, 20 (1962) (describing one abusive mother who “wished to be a kind, good mother, [but] repeat[ed] the behavior of her own mother toward herself” and another whose “impairment in mental functioning was probably the prime factor associated with poor control of aggressive impulses”).

16. Howard Dubowitz, *The Battered Child Syndrome Paper: Influence on the Field of Child Neglect*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT 51, 53 (Richard D. Krugman & Jill E. Korbin eds., 2013).

17. DUNCAN LINDSEY, THE WELFARE OF CHILDREN 27 (2d ed. 2004).

18. See *infra* notes 176–79 and accompanying text (comparing the scope of mandatory reporting laws proposed by Kempe and his colleagues to the broader requirements actually enacted).

19. Matthew I. Fraidin, *Stories Told and Untold: Confidentiality Laws and the Master Narrative of Child Welfare*, 63 ME. L. REV. 1, 2, 8–16 (2010); see also Cynthia Godsoe, *Parsing Parenthood*, 17 LEWIS & CLARK L. REV. 113, 121–29 (2013) (explaining the consequences of the flawed framework of current child protection policies); Annette R. Appell, *On Fixing “Bad” Mothers and Saving Their Children*, in “BAD” MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA 356 (Molly Ladd-Taylor & Lauri Umansky eds., 1998) (describing the unique situation of “bad” mothers in the child welfare system because of the punitive nature of the system and the state’s inability to be a “good” parent).

20. Neil Gilbert, *Conclusion: A Comparative Perspective*, in COMBATING CHILD ABUSE: INTERNATIONAL PERSPECTIVES AND TRENDS 232 (Neil Gilbert ed., 1997) (comparing the “Child Protection Model” in the United States to the “Family Services Model,” which describes the systems of several European nations); see also ISLA WALLACE & LISA BUNTING, AN EXAMINATION OF LOCAL, NATIONAL AND INTERNA-

viewed child maltreatment as “psychopathology,” with public agencies’ responses to such maltreatment framed in direct response to the diagnosed pathology, ignoring contextual elements that contribute to the maltreatment.²¹ Involvement with the child protection system is stigmatizing—to parents, to mothers, and especially to the poor and black mothers who are disproportionately labeled as bad parents through the child protection system.²² The parental-fault focus also shapes the media’s portrayal of child maltreatment as a legal and policy issue.²³

The parental-fault model logically focuses on a parent’s individual actions deemed abusive or neglectful and attributes responsibility for those actions to the individual parent—not broader familial, social, economic, or other factors. Cases involving domestic violence between a parent (usually a mother) and her partner, who is unrelated to the child, provide a vivid illustration. Needing to find fault with the mother, CPS systems blame her for “failure to protect” her child from the partner’s abuse or even from exposure to the partner’s abuse of the parent simply because the parent is in a relationship with the abusive partner.²⁴ Child protection agencies expect women to leave their partners without considering the many complex factors that prevent such decisions.²⁵ The simplistic diagnosis of the problem leads to service plans that fail to meet individual families’ needs.²⁶

TIONAL ARRANGEMENTS FOR THE MANDATORY REPORTING OF CHILD ABUSE: THE IMPLICATIONS FOR NORTHERN IRELAND 12 (2007), available at http://www.nspcc.org.uk/Inform/publications/downloads/mandatoryreportingNI_wdf51133.pdf (same).

21. Richard J. Gelles, *Child Abuse as Psychopathology: A Sociological Critique and Reformulation*, in CHILD ABUSE AND VIOLENCE 49 (David G. Gil ed., 1979).
22. See Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 97 (“[B]lame is often in the minds of the parents, the community, and many workers when a child is labeled maltreated.”); Melissa L. Breger, *The (In)visibility of Motherhood in Family Court Proceedings*, 36 N.Y.U. REV. L. & SOC. CHANGE 555 (2012) (describing negative views of mothers in child abuse and neglect cases); Marie Ashe, “Bad Mothers,” “Good Lawyers,” and “Legal Ethics,” 81 GEO. L.J. 2533, 2547 (1993) (describing the “gendered focus of child dependency law” as imposing a “stigma of ‘badness’” on women); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 28 (2002) (describing stigma attached to parents of foster children).
23. AXEL AUBRUN & JOSEPH GRADY, HOW THE NEWS FRAMES CHILD MALTREATMENT: UNINTENDED CONSEQUENCES (2003), available at http://www.issuelab.org/resource/how_the_news_frames_child_maltreatment_unintended_consequences.
24. *E.g.*, *Nicholson v. Williams*, 203 F. Supp. 2d 153 (E.D.N.Y. 2002).
25. Jane C. Murphy & Margaret J. Potthast, *Domestic Violence, Substance Abuse, and Child Welfare: The Legal System’s Response*, 3 J. HEALTH CARE L. & POL’Y 88, 113–14, 116 (1999).
26. Murphy and Potthast found that none of the cases they studied had anything other than boilerplate service plans, violating the legal mandate for more contextual plans. *Id.* at 117.

The child welfare system can also provide some assistance to families facing poverty and related stressors—but only after child protection agencies investigate a charge that a poor parent has abused or neglected his or her child.²⁷ One parent in a community with a disproportionately high rate of child-protection-agency involvement described the issue powerfully:

[T]he advertisement, it just says abuse. If you being abused, this is the number you call. . . . It doesn't say if I'm in need of counseling, or if I'm in need of my children don't have shoes, if I just can't provide groceries even though I may have seven kids, but I only get a hundred something dollars food stamps.²⁸

As a logical extension of its focus on individual parental fault, the system separates parents deemed bad both from their children and often from other family members who are trying to help both parent and child—a result that can undermine parents' rehabilitation and thus their child's interests. Two recent cases that gained local media attention illustrate the point: Anna Brown lost her two children to foster care after a tornado destroyed her home, she lost her job, and utilities to her new home were cut off and she used small fires in the home to keep her and her children warm.²⁹ When police were finally called, Ms. Brown did not seem lucid; she may have had unaddressed mental health problems.³⁰ The family court ordered that Brown's children live with Brown's mother on the condition that she not let Brown live with her.³¹ Brown's mother had wanted to take both mother and child in so she could protect and raise her grandchildren and help her daughter.³² Denied that support, Brown became homeless.³³ She later died in a jail cell from an undiagnosed blood clot.³⁴ In another case, Shakur Knight was taken from his mother at birth because he was born with cocaine in his system.³⁵ Authorities refused to release

27. Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1485 (2012).

28. Dorothy E. Roberts, *The Racial Geography of Child Welfare: Toward a New Research Paradigm*, 87 CHILD WELFARE 125, 145 (2008).

29. Christine Byers, *Woman Unhappy with Care at St. Mary's Hospital is Arrested for Trespassing, Dies in Jail*, ST. LOUIS POST-DISPATCH, Mar. 25, 2012, at A1, http://www.stltoday.com/news/local/crime-and-courts/woman-unhappy-with-care-at-st-mary-s-hospital-is/article_ed640f3d-64a0-516c-88ff-fb770b5e9677.html. In full disclosure, I became involved in the court case regarding Ms. Brown's children months after she died. The material discussed is based on publicly reported details only.

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. Nancy Cambria, *Safety Cracks in Missouri Foster Policies*, ST. LOUIS POST-DISPATCH, Mar. 31, 2012, at A1, http://www.stltoday.com/news/local/metro/safety-cracks-in-foster-policies/article_d2900118-de9c-5f22-abe3-33cce71104d8.html.

Shakur to his father, a fit parent, because Shakur's parents lived together and his father refused to move out or make Shakur's mother move out (the parents were jointly raising other children).³⁶ Shakur was subsequently abused in foster care, suffering multiple fractures, and retinal and subdural hemorrhaging.³⁷

The forced separation of these parents from their own family supports occurred contrary to social science evidence suggesting that these parents' rehabilitation, and thus their children's long-term interests, are best served by keeping them as close as possible to their children and other family supports, especially when parents have substance-abuse problems.³⁸ These separations also reflect a remarkably unnuanced approach to difficult situations. Even when a mother's drug addiction prevents her from adequately parenting her child, living in the same home with his or her mother would not necessarily risk the child's safety—especially when there is another fit parent or other family caretaker. The system found parental fault (drug abuse) and removed the child without considering any alternative measures to keep the child safe.

The existing system also treats children outside of their family and community context, especially after it removes children from families. The system often ignores children's connection to their parent, following what Annette Appell has called the "myth of separation."³⁹ The foster care system has only in recent years gained a greater appreciation for the value of placing children with extended family members rather than strangers.⁴⁰ The foster care system frequently disrupts other elements of the child's life; placement in foster care often means placement in a new school, surrounded by completely new children and new teachers, with bad results for children.⁴¹

36. *Id.*

37. *Id.*

38. Ellen M. Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Response*, 75 UMKC L. REV. 789, 832–33 (2007) (collecting research).

39. Annette Ruth Appell, *The Myth of Separation*, 6 NW. J. L. & SOC. POL'Y 291 (2011).

40. Rob Geen, *Kinship Foster Care: An Ongoing, yet Largely Uninformed Debate*, in KINSHIP CARE: MAKING THE MOST OF A VALUABLE RESOURCE 1,1 (Rob Geen ed., 2003) (describing the shift from 1980s, when kinship foster care was rare, to the early 2000s, when "child welfare agencies increasingly consider kin as the first placement choice when foster care is needed").

41. *E.g.*, NATIONAL WORKING GROUP ON FOSTER CARE AND EDUCATION, EDUCATION IS THE LIFELINE FOR YOUTH IN FOSTER CARE 2 (2011), available at <http://www.americanhumane.org/children/stop-child-abuse/advocacy/educationfostercareresearchdatasheetjuly2011-00005200.pdf> (last visited Oct. 15, 2013) (presenting data on the number of foster-care placements and the effect on foster children of changing schools); Peter J. Pecora et al., *Assessing the Educational Achievements of Adults Who Were Formerly Placed in Family Foster Care*, 11 CHILD & FAM. SOC. WORK 220 (2006).

The existing system does account—somewhat—for the value of the parent–child relationship. The law requires state agencies to make “reasonable efforts” to prevent the need for removing children and, once children are removed, to reunify them with their parents.⁴² Many CPS agencies now use techniques such as family group decision-making, in which extended family members and other people chosen by the family gather to discuss alternatives to foster care, to develop plans to keep children safe without using foster care.⁴³ In addition, a growing number of CPS agencies use “differential response” to provide less coercive and stigmatizing interventions for families with children at relatively low risk of harm.⁴⁴ CPS agencies report that they provide services to many more intact families than to children in foster care,⁴⁵ although the range and quality of these services may be questioned.⁴⁶ These elements, however, exist in the context of a broader legal structure that depends on reporting, investigating, and finding parental fault. CPS agencies generally provide services to keep families intact only after they have first investigated allegations of abuse or neglect and found parental fault. And, as described more fully in section I.B., the present system’s focus on parental fault has neither succeeded in providing effective services to prevent maltreatment and improve family functioning nor adequately protected children from the most severe forms of abuse.

B. The Present Parental-Fault Paradigm Has Not Succeeded

In the present child welfare system, the severe cases for which a parental-fault paradigm is appropriate are far outnumbered by less dangerous cases. The system largely deals with parents who have unaddressed or inadequately addressed mental health conditions or substance-abuse problems and with families that have a variety of poverty-related stressors—like unstable housing and employment, violent neighborhoods, and bad schools. These are cases with few true villains and many flawed but sympathetic victims—including the parents deemed perpetrators.⁴⁷ For the majority of child welfare cases,

42. 42 U.S.C. § 671(a)(15) (2006).

43. For a summary of family group decision-making and listing of research into it, see AM. HUMANE ASS’N, *Family Group Decision Making*, <http://www.americanhumane.org/children/programs/family-group-decision-making/> (last visited Aug. 2, 2013).

44. *Infra* section III.B.

45. CHILD MALTREATMENT 2011, 81–95, U.S. DEP’T HEALTH & HUM. SERVS., ADMIN. FOR CHILD. & FAMILIES (2012), available at <http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf>.

46. *Infra* notes 112–17 and accompanying text.

47. See Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 96 (arguing that most

we apply a system designed for parents who engage in a pattern of clearly dangerous and morally culpable behavior to much more morally fraught situations, in which assigning fault can generously be described as an inexact art. At the same time, many children continue to face death and severe injury from abuse in alarming numbers. Some have even claimed that child protection agencies remain unaware of the majority of maltreated children.⁴⁸ Our system is both under- and over-inclusive; many children who need protection do not receive it, and many are forced into our child protection system despite being poor fits for it.⁴⁹

Much of the public policy debate in this field focuses on what should be done once state authorities remove children from their families and place them in foster care.⁵⁰ This focus tends to avoid critical discussion of the parental fault approach and, rather, tends to assume that fault has already been assigned and the issues relate to when the child can reunify with a parent or how the child can leave foster care to a new permanent home. This focus on a relatively narrow set of cases—those in which CPS removes children from their families—does not yield a comprehensive understanding of the child welfare system because these cases represent less than 10% of all cases touched by that system (see Table 1).

Analyzing the present child welfare system and its parental-fault paradigm requires a basic understanding of the system's full scope. In 2011:

- The child welfare system had 3.4 million child protection hotline referrals⁵¹ involving roughly 6.2 million children.⁵² Most of these calls were made by mandatory reporters—individuals le-

instances labeled “maltreatment” result from a constellation of poverty, mental health conditions, social isolation, domestic violence, and assorted other problems); Edwina G. Richardson-Mendelson, *Remarks Delivered April 13, 2012 to the Brooklyn Law School Symposium on Reforming Child Protection Law: A Public Health Approach*, 21 J.L. & POL'Y 141, 142 (2012) (describing her docket of impoverished and overwhelmed parents, many of whom were themselves maltreated); Gary B. Melton, *How Strong Communities Restored My Faith in Humanity: Children Can Live in Safety*, in PREVENTING CHILD MALTREATMENT: COMMUNITY APPROACHES 82, 85 (Kenneth A. Dodge & Doriane Lambelet Coleman eds., 2009) (“[M]ost cases . . . do not involve evil or sick parents.”).

48. Ruth Gilbert et al., *Developing Services for a Public Health Approach to Child Maltreatment*, 20 INT'L J. CHILD. RTS. 323, 326 (2012).

49. Thomas L. Hafemeister, *Castles Made of Sand? Rediscovering Child Abuse and Society's Response*, 36 OHIO N.U. L. REV. 819 (2010).

50. The two leading federal policy changes of the last two decades focus on more effectively serving children in foster care and speed their exit from it. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949; Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115.

51. CHILD MALTREATMENT 2011, *supra* note 45, at 5.

52. *Id.* at 6.

gally required to report suspected abuse or neglect to child protection authorities.⁵³ These referrals amount to a large proportion of all American children; by the time they turn eighteen, about 15% of all children born in the United States will be reported to a child protection agency.⁵⁴ In one state, 13.9% of all children were reported to CPS authorities by the age of five.⁵⁵

- 1,647,214 of those reports, involving 3,049,679 children,⁵⁶ were “screened-in,” meaning CPS agencies deemed the reports to allege facts that, if true, would constitute abuse or neglect.⁵⁷ In most jurisdictions, state law requires CPS agencies to investigate all screened-in reports.⁵⁸
- CPS agencies “substantiated”—made an administrative finding that the child was abused or neglected—regarding 676,569 children, about 22% of the total.⁵⁹ These findings are based on legal definitions of abuse or neglect that are broad enough to encompass a wide range of behavior.⁶⁰
- CPS agencies removed 252,320 children from their homes.⁶¹ Only 8.3% of all children subject to child abuse or neglect reports were placed in foster care; the remaining 91.5%—2.7 million children—never left home.
- The number of children with extended stays in foster care was even smaller. The number of children who left foster care in less than six months after the state removed them was 67,522.⁶² Thus, the children subject to the category of cases that has received the most attention—children removed from their families and placed in foster care for some extended period of time—is

53. *Id.* at 8. The cited statistic refers to “professional[]” reporters who are generally mandated by law to report suspected abuse or neglect. *See infra* section III.A.

54. Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 92.

55. A longitudinal study in California found that 293,441 of the 2,112,277 children born in that state during a four-year period were reported to CPS by age five. Emily Putnam-Hornstein et al., *A Public Health Approach to Child Maltreatment Surveillance: Evidence from a Data Linkage Project in the United States*, 20 CHILD ABUSE REV. 256, 261, 265 (2011). The rate is more than double for black children—29.7%. *Id.* at 266.

56. CHILD MALTREATMENT 2011, *supra* note 45, at 11, 30.

57. “Screened-out” cases involve requests for assistance, not reports of abuse or neglect, or allegations that, even if true, would not rise to the level of abuse or neglect. *Id.* at 5–6.

58. *See infra* section III.B.

59. CHILD MALTREATMENT 2011, *supra* note 45, at 32.

60. *See infra* Part IV.

61. THE AFCARS REPORT: PRELIMINARY FY 2011 ESTIMATES AS OF JULY 2012, 1, U.S. DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES (2012), available at <http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf>. [hereinafter AFCARS REPORT].

62. *Id.* at 3.

even smaller, 184,798, or 6.1% of all children who were the subjects of screened-in CPS reports.⁶³

At the same time, state authorities attributed 1545 children's deaths to abuse or neglect in 2011.⁶⁴ Rates of child fatalities from abuse or neglect have remained fairly steady; between 2006 and 2010, they fluctuated between a low of 2.00 per 100,000 children to a high of 2.32 per 100,000.⁶⁵ These rates of child maltreatment deaths place the United States at the bottom of the scale of rich nations, and more than double the rates of comparable nations.⁶⁶ In the United States, the number of child fatalities from abuse or neglect has remained fairly steady, at least back to the 1970s, while rates declined in many other rich nations.⁶⁷ Although some have suggested that the modern child welfare system, especially the advent of mandatory reporting and investigation statutes, has reduced child fatalities,⁶⁸ the more detailed empirical studies have found no evidence of any correlation, let alone causation, nor any clear evidence that maltreatment-related fatalities have declined.⁶⁹ The rate of child fatalities has even increased somewhat in recent decades, from about 1.3 deaths per 100,000 children in the mid-1980s, to 1.92 in the mid-1990s, to slightly above 2.00 in recent years,⁷⁰ although this may result from improved procedures

63. The 252,320 children removed from their homes minus 67,522 children who left foster care in less than six months equals 184,798 children removed from their homes and placed in foster care for six months or more.

64. CHILD MALTREATMENT 2011, *supra* note 45, at 63.

65. CHILD MALTREATMENT 2010, 65, U.S. DEPT OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES (2011), available at <http://archive.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf>. The rate was 2.10 in 2011, the most recent year with available data. CHILD MALTREATMENT 2011, *supra* note 45, at 63.

66. The United States ranked 26th out of twenty-seven nations with a child fatality from maltreatment rate of 2.2 per 100,000 children. Twenty-three nations had rates under 1.0. A LEAGUE TABLE OF CHILD MALTREATMENT DEATHS IN RICH NATIONS 4, UNICEF (2003), available at <http://www.unicef-irc.org/publications/pdf/repcard5e.pdf>.

67. UNICEF reports that American deaths from child maltreatment remained steady between the 1970s and the 1990s, while rates declined in fourteen of twenty-seven nations studied. *Id.* at 9.

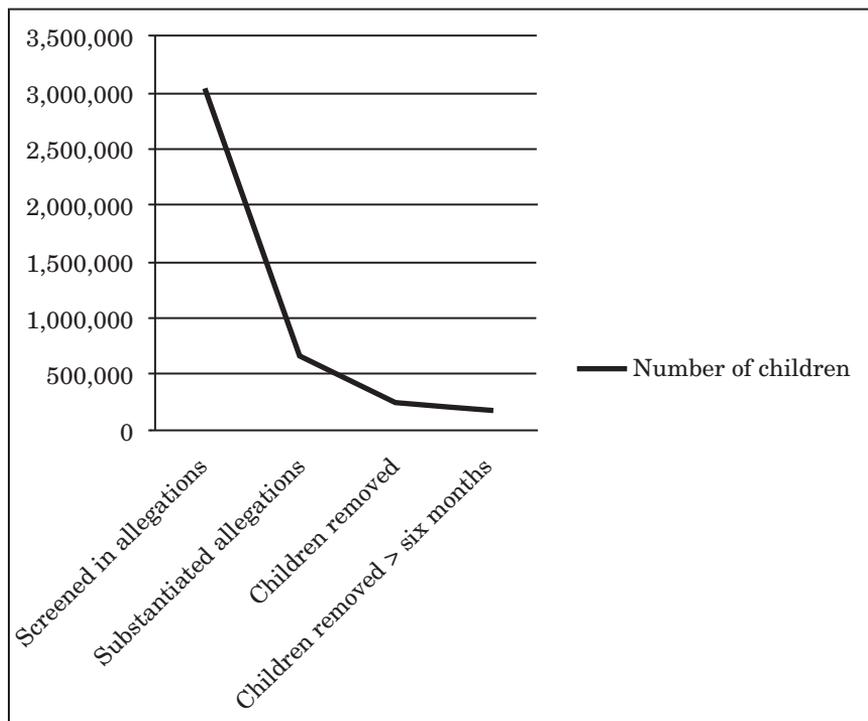
68. DOUGLAS J. BESHAROV, RECOGNIZING CHILD ABUSE 10–11 (1990).

69. LINDSEY, *supra* note 17, at 130–37. See also Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 95 (describing as “unclear” whether child maltreatment fatalities have declined).

70. David Wiese & Deborah Daro, *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1994 Annual Fifty State Survey* (Nat'l Comm. to Prevent Child Abuse, Working Paper No. 808, 1996), available at <http://www.liftingtheveil.org/ncpca94.htm> (last updated Jan. 18, 1996), and CHILD MALTREATMENT 2010, *supra* note 65, at 65.

to review child deaths and identify those caused by maltreatment.⁷¹ And very large numbers of reports and investigations, most of which are not substantiated and most of which do not lead to child removals, have been the hallmark of our system for several decades.⁷²

Table 1. Number of Children Impacted by CPS Annually



The system that has been in place for a generation thus places a parental-fault paradigm across a huge range of cases, at least the three million children subject to investigations, most of whom are not good fits for that paradigm. In so doing, the system imposes at least five kinds of harm.

First, the present system's wide scope prevents it from protecting children against the most severe forms of abuse—the very forms for which the system was created to protect against. Roughly 1500 chil-

71. Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 95 n.12.

72. Douglas J. Besharov & Lisa A. Laumann, *Child Abuse Reporting*, 33 Soc. Sci. & Mod. Soc'y 40 (1996).

dren are killed by abuse or neglect each year,⁷³ and some significant number had prior contact with CPS.⁷⁴ Moreover, reviews of many of these fatalities found some mistakes by child protection authorities; one New York City study found 396 mistakes in a review of 212 child fatalities over three years, suggesting a significant inability of CPS authorities to complete thorough investigations in all cases.⁷⁵ These child fatality statistics have remained stable for decades, suggesting a long-standing and unresolved problem within the prevailing child-welfare paradigm.⁷⁶ The stagnant number of fatalities should provide an impetus to reduce the most severe harms. There is little reason to conclude that the extremely broad scope of the present child welfare system is necessary to prevent those fatality numbers from increasing. As discussed in more depth below, declining to investigate less serious allegations likely improves the safety of affected children.⁷⁷ Beyond the child deaths and serious injuries that an overwhelmed child protection system fails to prevent, the present child-protection reporting system fails to identify a large share of cases, including cases involving severe abuse.⁷⁸ For instance, the federal government estimates that CPS only investigates 55% of cases involving sexual abuse of a child.⁷⁹

73. *Supra* notes 63–64 and accompanying text.

74. Estimates of child fatalities with prior CPS contact vary. In 1995, 48% of child fatalities involved children with whom CPS authorities had some prior contact. Douglas J. Besharov, Commentary, *Four Commentaries: How We Can Better Protect Children from Abuse and Neglect*, 8 *THE FUTURE OF CHILDREN* 120, 120 (1998). States reported that they had previously provided services to 10.2% of families in which child fatalities occurred in 2011. *CHILD MALTREATMENT 2011*, *supra* note 45, at 65–66. This figure does not include all children who were known to CPS authorities through prior investigations.

75. BETSY GOTBAUM, DANGEROUS MISTAKES: ANALYSIS OF ACS CORRECTIVE ACTIONS INVOLVING CHILD FATALITIES IN 2005, 3 (2007), available at http://www.nyc.gov/html/records/pdf/govpub/moved/pubadvocate/CHILDFATALITYREPORTWEB_FINAL.pdf (last visited Aug. 2, 2013).

76. DOUGLAS J. BESHAROV, *CHILD ABUSE AND NEGLECT REPORTING AND INVESTIGATION: POLICY GUIDELINES FOR DECISION MAKING* 1 (1988). Besharov attributed CPS's failure to protect children in these cases to the large burdens placed on CPS agencies to investigate less serious and unsubstantiated allegations, leading investigators to miss evidence and delay investigations. Besharov, *supra* note 74, at 120–21.

77. *See infra* notes 226–27 and accompanying text.

78. Natalie K. Worley & Gary B. Melton, *Mandated Reporting Laws and Child Maltreatment: The Evolution of a Flawed Policy Response*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 103, 104, 108, available at http://o-link.springer.com.library.unl.edu/chapter/10.1007/978-94-007-4084-6_13; Michael Wald, *Beyond Maltreatment: Developing Support for Children in Multiproblem Families* 16 (Stanford Law Sch., Working Paper No. 2205471, 2013), available at <http://ssrn.com/abstract=2205471>.

79. *FOURTH NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-4)*, 2004–2009, 8-6, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES (2010), available at <http://www.acf.hhs.gov/programs/opre/research/pro>

Moreover, evidence exists that by screening out and not investigating less severe cases, the quality of remaining investigations improves. A study of Missouri's "differential response" pilot—through which state officials only investigated more severe allegations and diverted less severe reports—concluded that by reducing the number of less serious investigations, authorities had more investigatory time to focus on sexual abuse cases.⁸⁰ Those investigations were more comprehensive, and police were able to gather enough evidence to arrest more perpetrators of sexual abuse and prevent them from preying on more children.⁸¹ More research is necessary to reach a certain conclusion, but the Missouri results comport with the logical intuition that focusing investigative resources on the most severe, highest-priority cases will improve authorities' ability to investigate such cases effectively.

Second, the system imposes child-protection investigations on a large number of children and parents who have no need for that intervention. These investigations are invasive of the right to family integrity and cause significant anxiety and other emotional distress.⁸² These invasions of liberty occur whenever a child-protection investigation occurs⁸³—millions of times every year.

Third, for the 700,000 or so children whom CPS agencies find to have been abused or neglected every year,⁸⁴ the current approach leads to parents' placement on state child protection registries. Placement on such registries imposes a legal prohibition on those parents working as childcare providers, bus drivers, and home health-aides.⁸⁵

ject/national-incidence-study-of-child-abuse-and-neglect-nis-4-2004-2009 [hereinafter NIS-4].

80. L. ANTHONY LOMAN, INST. OF APPLIED RESEARCH, DIFFERENTIAL RESPONSE IMPROVES TRADITIONAL INVESTIGATIONS: CRIMINAL ARRESTS FOR SEVERE PHYSICAL AND SEXUAL ABUSE (2005), available at <http://www.iarstl.org/papers/DiffRespAndInvestigations.pdf>.
81. *Id.* See also Jane Waldfogel, *Differential Response*, in PREVENTING CHILD MALTREATMENT: COMMUNITY APPROACHES, *supra* note 47, at 139, 145–46 (discussing this and other Missouri differential response studies).
82. See Doriane Lambelet Coleman, *Storming the Castle to Save the Children: The Ironic Costs of a Child Welfare Exception to the Fourth Amendment*, 47 WM. & MARY L. REV. 413 (2005); Josh Gupta-Kagan, *Beyond Law Enforcement: Camreta v. Greene, Child Protection Investigations, and the Need to Reform the Fourth Amendment Special Needs Doctrine*, 87 TUL. L. REV. 353 (2012); Besharov, *supra* note 74, at 121 (“[T]he determination that a report is unfounded can be made only after what is often a traumatic investigation and, inherently, a breach of parental and family privacy.”).
83. Gupta-Kagan, *supra* note 82, at 369.
84. See *supra* note 59 and accompanying text.
85. See, e.g., MO. REV. STAT. §§ 210.900–936 (2013) (including childcare workers, elder-care workers, and personal-care attendants on the list of professions requiring a clean registry); see generally ESTABLISHMENT AND MAINTENANCE OF CENTRAL REGISTRIES FOR CHILD ABUSE REPORTS, U.S. DEP’T OF HEALTH & HUMAN SERVS.,

This prohibition disproportionately affects lower-income families, who are over-represented among the families affected by CPS investigations and substantiations. This prohibition lasts years—the federal government reports that the norm is at least until the alleged victim of maltreatment has reached adulthood—without reference to parental rehabilitation.⁸⁶ By barring entire categories of employment and formally labeling a parent as abusive or neglectful, such placements trigger due process protections.⁸⁷ They hurt parents' employment prospects and thus limit parents' ability to provide for their children.⁸⁸ They have this effect whether a parent was found to have severely abused a child or to have more modestly neglected a child. Even when agencies conclude that a child does not need protection from a parent, the state limits the parent's employment options.

Moreover, child protection registries are plagued by inaccuracies. The Second Circuit has described administrative findings of abuse or neglect as “at best imperfect,” noting that three-quarters of administrative challenges to such findings are successful.⁸⁹ Challenges frequently only occur when the administrative findings lead a parent to lose a job,⁹⁰ and a long backlog of administrative challenges may exist in some jurisdictions,⁹¹ suggesting that many parents with legitimate claims do not challenge these administrative findings or cannot pursue a timely challenge of them.

These registries provide an important benefit; when a CPS agency finds that a parent has severely abused children, that person should not be placed in a position of trust regarding other children. But it is much harder to argue that the child protection registry annual listings of 700,000 adults—most of whom are not considered by CPS agencies to have done something warranting removal of a child—consistently serves that purpose. If a mother is deemed to have used “excessive corporal punishment” for disciplining a child with a belt and is

ADMIN. FOR CHILD. & FAMILIES (2011), available at https://www.childwelfare.gov/systemwide/laws_policies/statutes/centreg.pdf.

86. REVIEW AND EXPUNCTION OF CENTRAL REGISTRIES AND REPORTING RECORDS 3, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES (2011), available at https://www.childwelfare.gov/systemwide/laws_policies/statutes/registry.pdf (“Substantiated reports are usually retained longer, typically at least until the child victim has reached adulthood.”).

87. See, e.g., *In re W.B.M.*, 690 S.E.2d 41 (N.C. Ct. App. 2010).

88. *Id.* at 49; *Valmonte v. Bane*, 18 F.3d 992, 1001 (2d Cir. 1994). See also Hafemeister, *supra* note 49, at 897 (summarizing critiques of child protection registries).

89. *Valmonte*, 18 F.3d at 1003–04.

90. *Id.*

91. See John O'Brien, *NY Denied Thousands Accused of Child Abuse the Chance to Clear Their Name*, POST-STANDARD, Mar. 22, 2010, http://www.syracuse.com/news/index.ssf/2010/03/ny_denied_thousands_accused_of.html (describing long delays which led state officials to shred administrative requests).

thereby placed on a child protection registry⁹² or if she is deemed to have failed in protecting her children from an abusive boyfriend she subsequently left, preventing that woman from becoming a school bus driver or child care worker does not protect children at all. Rather, placing and keeping that mother on the child protection registry only imposes an economic burden on that mother and limits her ability to care for her children, thus hurting the very children whom the child protection system is designed to help.

Fourth, the present child protection system removes many children who could be adequately protected from abuse or neglect at home. Over recent decades, many commentators have argued that the child protection system removes children unnecessarily.⁹³ One can infer this conclusion from publicly reported data. For instance, states reported that 35% of all children removed from their families and placed in foster care are “nonvictims”—that is, ultimately deemed to not have been victims of abuse or neglect.⁹⁴ In addition, a very large percentage of children removed from their homes leave foster care in less than six months—67,522 in 2011, or 26.8% of all the children whom states removed and placed in foster care that year.⁹⁵ It is reasonable to infer that many, if not most, children who could return to their families so quickly were never at such a high risk as to justify a removal in the first instance. One state child protection agency recently acknowledged that the majority of children who enter and leave foster care in short periods of time “should have never come into care” in the first instance.⁹⁶

Other recent studies show that many children removed from their families are harmed more by the state placing them in foster care than similarly at-risk children left at home with their families. Joseph Doyle compared children removed from their families and placed in foster care with children with similarly troubled family situations whom CPS authorities nonetheless left at home. Doyle found that children placed in foster care had higher juvenile delinquency rates, higher teen birth rates, and lower earnings than children left at

92. *Valmonte*, 18 F.3d at 997.

93. See, e.g., Martin Guggenheim, *Somebody's Children: Sustaining the Family's Place in Child Welfare Policy*, 113 HARV. L. REV. 1718 (2000); Marsha Garrison, *Child Welfare Decisionmaking: In Search of the Least Drastic Alternative*, 75 GEO. L.J. 1745 (1987); Michael Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985 (1975).

94. CHILD MALTREATMENT 2011, *supra* note 45, at 91.

95. See *supra* note 62 and accompanying text.

96. The State of Arkansas so acknowledged in a recent federal filing. TITLE IV-E WAIVER DEMONSTRATION PROJECT PROPOSAL 14, ARK. DIV. OF CHILD. & FAMILY SERVS. (2012), available at http://archive.acf.hhs.gov/programs/cb/programs_fund/ar_waiver_proposal.pdf.

home.⁹⁷ The negative effects could last into adulthood; Doyle found that children removed from their parents and placed in foster care for any length of time were two to three times more likely to be arrested, convicted, and imprisoned for crimes as adults than similarly at-risk children left with their parents.⁹⁸ An earlier study found that young children moved from the custody of mothers who abused cocaine had worse behavioral problems than those children left with similar mothers.⁹⁹ Unnecessary removals from families and placement in foster care impose both the traumas of separating children from their parents¹⁰⁰ and the harms associated with foster care itself, including the toll of frequent moves from one foster home to another¹⁰¹ and the long-term harms of remaining in foster care for years¹⁰²—a too-common fate.¹⁰³

Removals may also harm children by catalyzing parents' "downward spiral."¹⁰⁴ A study of New York City foster children whose time

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97. Joseph J. Doyle, *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 AMER. ECON. REV. 1583, 1607 & n.2 (2007), available at http://www.mit.edu/~jjdoyle/fostercare_aer.pdf (and sources cited therein).
 98. Joseph J. Doyle, *Child Protection and Adult Crime: Using Investigator Assignment to Estimate Causal Effects of Foster Care*, 116 J. POL. ECON. 746, 748 (2008), available at http://www.mit.edu/~jjdoyle/doyle_jpe_aug08.pdf.
 99. Virginia Delaney-Black et al., *Teacher-Assessed Behavior of Children Prenatally Exposed to Cocaine*, 106 PEDIATRICS 782, 786 (2000). The study controlled for factors which might explain custody decisions, such as prenatal risk factors, and still found that "custody change . . . was a significant predictor" of behavioral problems. See also Kathleen Wobie et al., *To Have and to Hold: A Descriptive Study of Custody Status Following Prenatal Exposure to Cocaine*, 43 PEDIATRIC RES. 234 (1998), available at <http://www.nature.com/pr/journal/v43/n4s/full/pr19981518a.html> (finding worse developmental outcomes for substance-exposed infants placed out of their mothers' custody than those living in their mothers' custody at six months of age).
 100. See, e.g., JOSEPH GOLDSTEIN ET AL., THE BEST INTERESTS OF THE CHILD: THE LEAST DETRIMENTAL ALTERNATIVE 41–45 (1996).
 101. E. Christopher Lloyd & Richard P. Barth, *Developmental Outcomes After Five Years for Foster Children Returned Home, Remaining in Care, or Adopted*, 33 CHILD. & YOUTH SERVICES REV. 1383, 1384 (2011). The prevalence of placement changes is quite high. For instance, the District of Columbia government reported that it moved 38% of all foster children in 2011 from one placement to another. Many of these children had multiple placement changes, as there were 86% more total placement changes than children who experienced placement changes. DISTRICT OF COLUMBIA, CHILD & FAMILY SERVS., D.C. GOV'T, ANNUAL PUBLIC REPORT FY 2011, 28 (2012), available at <http://cfsa.dc.gov/publication/annual-report-2011-cfsa> (last visited Aug. 2, 2013).
 102. See, e.g., Lloyd & Barth, *supra* note 101 (finding that children who remained in foster care after five years had significantly worse outcomes than those who either returned home or were adopted).
 103. According to the most recent federal data, more than 78,000 children—20% of the total foster care population—had been in foster care for three or more years. AF-CARS REPORT, *supra* note 61, at 2 (2012).
 104. TIMOTHY ROSS ET AL., HARD DATA ON HARD TIMES: AN EMPIRICAL ANALYSIS OF MATERNAL INCARCERATION, FOSTER CARE, AND VISITATION 14 (2004), available at

in foster care overlapped with their mothers' incarceration found that the child protection agency's decision to remove children from parents and place them in foster care correlated with increased criminal activity by their mothers.¹⁰⁵ This criminal activity was mostly nonviolent, with 56% of all such activity drug-related.¹⁰⁶ Losing a child to foster care may push parents into desperation and leads many parents with substance-abuse problems to use more drugs because it removes a key motivator for keeping substance abuse in check—the need to keep themselves together for their children.¹⁰⁷ The study concludes that reducing the number of children removed into foster care can serve to prevent maternal criminal activity.¹⁰⁸ That conclusion may be too modest; unnecessary removals of children not only represent a failure to offer a less invasive option to parents, but can be so traumatizing for the parent that later efforts at rehabilitation are significantly more difficult.¹⁰⁹

Even when removals are justified, little evidence exists that foster care serves children's needs. “[T]here have been no randomised controlled trials comparing out-of-home with in-home care on the child's safety, health, achievements, and quality of life.”¹¹⁰ A public health approach demands data-driven decisions;¹¹¹ so the absence of rigorous data regarding the effectiveness of foster care is an essential fault of the present system.

Fifth, the present system misses opportunities to solve real social problems for some of society's poorest and most vulnerable children and families. Half of all children reported to CPS are “screened out,” more than three quarters of the remaining children are not the subjects of substantiated allegations, and more than 90% of the remaining children stay at home. Many of these families have deep problems, but the child welfare system does largely nothing for them.¹¹² Most families receive no services¹¹³ or “little more than a referral to possible services or no more than six months of in-home

<http://www.vera.org/pubs/hard-data-hard-times-empirical-analysis-maternal-incarceration-foster-care-and-visitation> (last visited Aug. 2, 2013).

105. *Id.* at 10, 14.

106. *Id.* at 10–11, 14.

107. SHEIGLA MURPHY & MARSHA ROSENBAUM, PREGNANT WOMEN ON DRUGS: COMBATING STEREOTYPES AND STIGMA 9–10 (1999).

108. ROSS ET AL., *supra* note 104 (executive summary).

109. For a fuller critique of intersections between incarceration and foster care, see Roberts, *supra* note 27.

110. Gilbert et al., *supra* note 48, at 326.

111. *See infra* note 150 and accompanying text.

112. See Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1453 n.644 (2005).

113. FRED WULCZYN ET AL., BEYOND COMMON SENSE: CHILD WELFARE, CHILD WELL-BEING, AND THE EVIDENCE FOR POLICY REFORM 86 (2005).

services.”¹¹⁴ CPS authorities have unique knowledge of families’ core needs and thus unique opportunities to help families address those needs. And the evidence makes plain that, in the aggregate, children and families who come to the attention of CPS authorities have a range of serious needs.¹¹⁵ For instance, the majority of young children involved in any way with CPS agencies are at high risk of developmental delays; even cases closed after an investigation reveal “exceptionally high . . . developmental risk.”¹¹⁶ But problems that existed when child-welfare agencies made contact with them are not resolved several years later, even when the families present problems for which interventions known to be effective exist.¹¹⁷ Some of these families have their problems progress to a point at which child-protection agencies must intervene more coercively. The child-welfare literature is replete with repeat cases of child maltreatment.¹¹⁸ Many more of these families simply continue on, their problems festering and leading to poor life outcomes, even poorer than for children from similar socio-economic backgrounds.¹¹⁹ These families include those that have problems sufficiently serious to trigger suspicion of maltreatment by a mandatory reporter but that a reporter chooses not to report (in violation of mandatory reporting laws)—a decision that correlates, unsurprisingly, with less severe suspicions.¹²⁰ These children

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114. Richard P. Barth, *Research Outcomes of Prenatal Substance Exposure and the Need to Review Policies and Procedures Regarding Child Abuse Reporting*, 80 CHILD WELFARE 275, 282 (2001). Barth suggests that this limited set of likely interventions renders CPS hotline calls as something other than punishment. *Id.* As argued above, such a perspective ignores the stigma of CPS involvement, the invasiveness of a CPS investigation, the stigma of a substantiated finding, and the economic harm of the state placing one’s name on a child protection registry.
115. See WULCZYN et al., *supra* note 113, at 86 (“Children who are entering child welfare services are clearly in need of a range of supportive activities. . . . [Their background] would seem to predict futures beset with significant health and mental health problems.”).
116. *Id.* at 172. For example, two- and three-year-old children involved with CPS have twice the average amount of problematic behavior. *Id.*
117. Abraham B. Bergman, *Child Protective Services Has Outlived Its Usefulness*, 10 ARCHIVES OF PEDIATRIC ADOLESCENT MED. 978, 978–79 (2010); Kristine A. Campbell et al., *Household, Family and Child Risk Factors After an Investigation for Suspected Child Maltreatment: A Missed Opportunity for Prevention*, 10 ARCHIVES PEDIATRIC ADOLESCENT MED. 943 (2010).
118. JANE WALDFOGEL, THE FUTURE OF CHILD PROTECTION 27 (1998).
119. Wald, *supra* note 78, at 16 (“[S]everal longitudinal studies have found that the long-term development of children reported to CPS agencies, regardless of whether the report is substantiated, is considerably worse than the development of children from similar socio-economic households and neighborhoods who have not been reported to CPS.”); see also *id.* at 22 (“[B]ecoming known to the CPS system does not lead to improved well-being for most of [sic] children . . .”).
120. Stephen W. Webster et al., *Overreporting and Underreporting of Child Abuse: Teachers’ Use of Professional Discretion*, 29 CHILD ABUSE & NEGLECT 1281, 1293 (2005).

may be spared some of the difficulties caused by CPS interventions, but they receive no interventions to address whatever may be occurring in their family lives.

This absence of help for families whose parents are not deemed bad enough for greater child-protection-system involvement is a symptom of the broader system design problem. By framing child maltreatment as an issue of pathological parents, the law has created an unhelpful binary—either a parent is acceptable or the parent commits maltreatment.¹²¹ Child protection authorities generally provide no services to any parent in the former category or too many in the latter. This legal binary does not comport with the level of risk to children. Substantiating abuse or neglect is essential to operating the present parental fault model; if a CPS agency cannot prove abuse or neglect, it has no authority to proceed. But, beyond the most severe cases, such substantiation bears little connection to the actual risk faced by children. One detailed study, comparing cases in which CPS agencies substantiated maltreatment allegations but did not remove children with cases in which CPS did not substantiate maltreatment allegations, found similar future risk to children in both groups.¹²²

C. Public Health Paradigm

A public health approach would differ from the existing model by focusing on parental fault and related coercive investigations and other interventions in a much narrower range of cases. It would develop a legal structure that would lead individuals and institutions with significant contact with children and families to make more effective service referrals. It would make decisions based on the best data available, after analyzing children's complete family and social environment.

Outlining the core principles of a public health approach requires explanation because the public health field does not use the term with great precision; one introductory textbook admits that public health "is an abstract concept, hard to pin down."¹²³ While the field histori-

121. Michael S. Wald, *Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 89, 90.

122. Patricia L. Kohl et al., *Time to Leave Substantiation Behind: Findings from a National Probability Study*, 14 CHILD MALTREATMENT 17, 23 (2009).

123. MARY-JANE SCHNEIDER, INTRODUCTION TO PUBLIC HEALTH xix (3d ed. 2011). See also BERNARD J. TURNOCK, PUBLIC HEALTH: WHAT IT IS AND HOW IT WORKS 9 (4th ed. 2009) (listing several definitions of public health). An oft-cited federal report offers this imprecise definition: "the fulfillment of society's interest in assuring the conditions in which people can be healthy." INST. OF MED., COMM. FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, THE FUTURE OF PUBLIC HEALTH 40 (1988), available at <http://www.nap.edu/catalog/1091.html>. See also Wendy K. Mariner, Review Essay, *Public Health and Law: Past and Future Visions*, 28 J.

cally focused on infectious diseases, it has expanded to include child maltreatment and many of its underlying risk factors, like mental health and substance abuse.¹²⁴ Indeed, multiple legal, social work, and public health commentators and institutions¹²⁵ have recognized that child maltreatment is a public health issue. This Article builds off of their work, recognizing that the law has shaped the existing parental-fault paradigm and could shape a public health approach.¹²⁶

This work, however, does not yet discuss the legal reforms necessary for a public health approach—especially when significant risk factors exist or maltreatment has already occurred. Multiple commentators have used a public health lens to criticize the present child welfare system.¹²⁷ But they only open the conversation, suggesting a more rigorous welfare state and social safety net without addressing how to respond to families with multiple risk factors of child maltreatment or parents who have already maltreated their children.¹²⁸ One commentator, for instance, urges greater investment in a “comprehensive prevention strategy,” especially expansion of primary prevention programs like early childhood programs and the use of mental-health and substance-abuse screenings for parents of young children, followed by evidence-based treatments for specific conditions.¹²⁹ Calls for a stronger safety net—what public health calls primary prevention—are relatively easy analytically and unite otherwise divergent

HEALTH POL., POL'Y & L. 525, 525–28 (2003) (describing varied and broad definitions of public health).

124. ROGER DETELS ET AL., OXFORD TEXTBOOK OF PUBLIC HEALTH: CURRENT SCOPE AND CONCERNS IN PUBLIC HEALTH § 1.1 (4th ed. 2004).
125. CHILD MALTREATMENT SURVEILLANCE: UNIFORM DEFINITIONS FOR PUBLIC HEALTH AND RECOMMENDED DATA ELEMENTS 4, U.S. DEP'T OF HEALTH & HUMAN SERVICES, CENTERS FOR DISEASE CONTROL & PREVENTION (2008), available at http://www.cdc.gov/violenceprevention/pdf/cm_surveillance-a.pdf.
126. Scott Burris et al., *Making the Case for Laws that Improve Health: A Framework for Public Health Law Research*, 88 MILLBANK Q. 169, 170 (2010).
127. For instance, Martin Guggenheim concludes a sharp critique of the modern child welfare system by stating “If we could start over and conceive of child welfare as a public health or shared social problem . . . we could develop policies that address directly and proactively those conditions that adversely affect the health and welfare of poor children in the United States.” MARTIN GUGGENHEIM, WHAT'S WRONG WITH CHILDREN'S RIGHTS 211 (2005); see also Appell, *supra* note 39, at 298 (calling for “a social justice or a public health approach” that would seek to improve social, economic, and mental health of children and parents and avoid removals).
128. GUGGENHEIM, *supra* note 127, at 211.
129. Marsha Garrison, *Reforming Child Protection: A Public Health Perspective*, 12 VA. J. SOC. POL'Y & L. 590, 621–30 (2005); see also Francie Zimmerman & James A. Mercy, *A Better Start: Child Maltreatment as a Public Health Priority*, ZERO TO THREE, May 2010, at 4, 8–9, available at <http://www.zerotothree.org/maltreatment/child-abuse-neglect/30-5-zimmerman.pdf> (calling for various prevention efforts as a public health strategy).

approaches.¹³⁰ It is hard to object, for instance, to increased screening for conditions that are risk factors for abuse and neglect like parental depression,¹³¹ to voluntary programs offered to entire populations with a strong evidence base¹³² of preventing child maltreatment and saving long-term costs,¹³³ or to greater federal funding for research into public health tools and evidence-based services.¹³⁴ The harder

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130. For instance, Elizabeth Bartholet sharply disagrees with Guggenheim over how many children should be removed and how quickly and aggressively parental rights should be terminated. Compare Martin Guggenheim, *Somebody's Children: Sustaining the Family's Place in Child Welfare Policy*, 113 HARV. L. REV. 1716 (2000), with ELIZABETH BARTHOLET, *NOBODY'S CHILDREN: ABUSE AND NEGLECT, FOSTER DRIFT, AND THE ADOPTION ALTERNATIVE* (1999), and Elizabeth Bartholet, Reply, *Whose Children? A Response to Professor Guggenheim*, 113 HARV. L. REV. 1999 (2000). Bartholet also calls for "universal home visitation or some comparable program designed to provide families with support and children with protection during the vital periods of pregnancy and early infancy." BARTHOLET, *NOBODY'S CHILDREN*, *supra*, at 239; see also Elizabeth Bartholet, *Creating a Child-Friendly Child Welfare System: Effective Early Intervention to Prevent Maltreatment and Protect Victimized Children*, 60 BUFF. L. REV. 1323, 1338 (2012) (discussing the discretion of courts and child protective services in low-risk cases that do not necessitate coercive CPS action such as removal and termination of parental rights).
131. See, e.g., Sheila Smith, *Public Health Approaches to Child and Parent Screening: Implications for Child Protection*, 21 J.L. & POL'Y 59 (2012) (explaining how increased screening for maternal depression can aid child welfare). Congress provided funding for such screening in the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, § 2952, 124 Stat. 119, 226–28 (2010) (codified at 42 U.S.C. § 712).
132. Programs with a strong evidence base are rare, and one is well-cautioned against an overly broad proposal. See, e.g., Michael S. Wald, *Preventing Maltreatment or Promoting Positive Development—Where Should a Community Focus Its Resources?*, in PREVENTING CHILD MALTREATMENT, *supra* note 47, at 182, 186 (describing the relative paucity of programs with such a strong evidence base).
133. See, e.g., WULCZYN et al., *supra* note 113, at 141 (recommending "funding and implementation of prevention programs for families of young children who are at risk of or identified with maltreatment" as a means of reducing abuse and neglect and the need for coercive CPS interventions and describing some of the features of evidence-based programs).
134. Garrison, *supra* note 129, at 633. Nurse home-visiting programs provide an example. Nurses regularly visit first-time, young, poor mothers during pregnancy and for two years after birth and help identify and resolve various needs, resulting in reduced child maltreatment (and other various social problems) and emergency room visits, and, through such reductions, saving money. The RAND Corporation found that the program saves \$5.70 for every dollar spent on high-risk families and \$1.26 for every dollar spent on low-risk families. M. REBECCA KILBURN & LYNN KAROLY, *THE ECONOMICS OF EARLY CHILDHOOD POLICY: WHAT THE DISMAL SCIENCE HAS TO SAY ABOUT INVESTING IN CHILDREN* 16 (2008), available at http://www.rand.org/content/dam/rand/pubs/occasional_papers/2008/RAND_OP227.pdf; see also David L. Olds et al., *Preventing Child Abuse and Neglect with Home Visiting by Nurses*, in PREVENTING CHILD MALTREATMENT, *supra* note 47, at 29, 40 (describing a study in which low-income mothers visited by nurses during and after pregnancy showed dramatically reduced rates of sickness and child maltreatment than similar mothers who did not receive in-home visits).

question is how to reform child welfare law to apply a public health approach in secondary and tertiary prevention situations.

The social science literature is more vague than the legal literature. Abraham Bergman recommends replacing much of our current child protection reporting and investigation infrastructure with an army of public health nurses who will provide services “to at-risk families before the occurrence of abuse or neglect.”¹³⁵ Bergman then concedes that his proposal faces significant obstacles—fiscal constraints and the shortage of public health nurses¹³⁶—and does not describe the legal reforms necessary to achieve it. Other articles articulate a philosophical grounding for a public health approach to child maltreatment,¹³⁷ articulate the value of a public health approach,¹³⁸ conceptualize primary, secondary, and tertiary prevention,¹³⁹ identify specific programs that seem to reduce risk factors for child abuse and neglect,¹⁴⁰ and call for more “urgent development” of services for parents to prevent child abuse and neglect.¹⁴¹ All offer important contributions but lack calls for specific legal reforms.

This Article does not intend to be overly critical of this existing research. Many authors discussed acknowledge the work that remains: Marsha Garrison, for instance, notes the “massive research effort” that building a public health approach requires.¹⁴² Others acknowledge that the “knowledge base for a public health approach to child abuse and neglect is still in its infancy.”¹⁴³ Rather, this Article points out the large amount of legal reforms necessary to structure a public health approach to child welfare, and the imprecisely defined contours of a public health approach.

A public health approach would address child welfare differently than the present parental-fault paradigm. For purposes of this Arti-

135. Bergman, *supra* note 117, at 978–79.

136. *Id.*; Abraham B. Bergman, *A Pediatrician’s Perspective on Child Protection*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 68.

137. Richard Reading et al., *Promotion of Children’s Rights and Prevention of Child Maltreatment*, 373 THE LANCET 332 (2009).

138. *E.g.*, Melissa O’Donnell et al., *Child Abuse and Neglect—Is It Time for a Public Health Approach?*, 32 AUSTR. & N.Z. J. PUB. HEALTH 325 (2008).

139. *Id.* at 328. *See also* Cathryn Hunter, *Defining the Public Health Model for the Child Welfare Services Context*, NAT’L CHILD PROTECTION CLEARINGHOUSE (Sept. 2011), available at <http://www.aifs.gov.au/nch/pubs/sheets/rs11/rs11.pdf> (outlining the three levels of public health programs for addressing child maltreatment).

140. Jane Barlow & Rachel Calam, *A Public Health Approach to Safeguarding in the 21st Century*, 20 CHILD ABUSE REV. 238, 245–49 (2011) (describing the British Healthy Child Programme and the American Triple P Parenting program).

141. Gilbert et al., *supra* note 48, at 338.

142. Garrison, *supra* note 129, at 630.

143. O’Donnell et al., *supra* note 138, at 327; *see also* Gilbert, et al., *supra* note 48, at 339 (calling for development of a stronger research agenda).

cle, a “public health approach to child welfare” includes the following elements:

First, a public health approach seeks to apply the most effective interventions and to apply the most invasive interventions only when necessary. Its goal is to achieve the best health outcomes, broadly defined, for children and families. Assigning fault or blame or using government’s coercive powers may be called for, but only when necessary to achieve a health outcome because public health recognizes that individual freedoms are important and that unnecessary infringements on those freedoms can reduce the public’s faith in public health efforts.¹⁴⁴

Second, a public health approach considers children in their full context—as parts of families and wider communities. The public health field insists on considering the social environment in which a health problem exists, applying an “ecological” analysis.¹⁴⁵ Such an analysis is consistent with prevailing child development theories, which identify environmental factors beyond parents and other family members as essential elements of children’s well-being.¹⁴⁶ A public health approach thus must at least consider interventions that address that environment—an approach that necessarily shifts blame off of individuals.¹⁴⁷ Parents who mistreat their children are not necessarily “degenerate.” Rather, they are likely “enmeshed in a web of problems” including their own mental health conditions, poverty, and their children’s behavioral issues.¹⁴⁸ In addition, a public health approach may seek to preserve or strengthen the positive elements of a child’s environment and use them to help improve the environment’s harmful elements.¹⁴⁹

Third, a public health approach relies on data to identify the most effective interventions available, and invests in research to identify such interventions.¹⁵⁰ This principle ensures, as much as is possible, that authorities choose interventions based on what is most likely to work rather than political pressures to err on the side of interven-

144. Jonathan Todres, *Moving Upstream: The Merits of a Public Health Law Approach to Human Trafficking*, 89 N.C. L. REV. 447, 500 (2011).

145. TURNOCK, *supra* note 123, at 47–86; SCHNEIDER, *supra* note 123, at 233 (“An ecological model looks at how the social environment, including interpersonal, organization, community, and public policy factors, supports and maintains unhealthy behaviors.”) *Id.*

146. WULCZYN ET AL., *supra* note 113, at 10.

147. SCHNEIDER, *supra* note 123, at 226. *See also infra* notes 166–67 and accompanying text (describing Barbara Bennett Woodhouse’s “environmentalist paradigm” for analyzing children’s cases, *supra* note 11).

148. Gilbert, *supra* note 20, at 232.

149. *See* Melton, *supra* note 47 (describing one such effort and its positive outcome data).

150. Garrison, *supra* note 129, at 599–611 (2005); WULCZYN ET AL., *supra* note 113, at 42–43.

tion¹⁵¹ or flawed decision-making processes that can result from emotionally charged issues such as child maltreatment.¹⁵² Marsha Garrison has established how our child welfare system lacks proven, standardized diagnostic tools and evidence-based treatments.¹⁵³ A recent federal review identified an “urgent need” to fill “major substantive and methodological gaps in the evidence” for interventions to help maltreated children.¹⁵⁴

Fourth, a public health approach focuses on prevention as preferable to reactive interventions¹⁵⁵ and offers a continuum of interventions depending on the level of risk that child maltreatment of any kind will occur. The field categorizes efforts into primary, secondary, and tertiary prevention.¹⁵⁶ Primary prevention seeks to prevent people’s exposure to risk factors for child maltreatment by providing some intervention to a wide population. Secondary prevention seeks to reduce the risk of harm by eliminating or mitigating risk factors that are already present through services targeted at families in which certain risk factors are present. Tertiary prevention “seeks to minimize disability” through interventions after maltreatment has occurred¹⁵⁷ and recognizes that maltreatment often does not lead to perceptible harm to a child’s development.¹⁵⁸ Public health importantly includes a response to past child maltreatment as tertiary *prevention*—the idea

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151. See Paul Chill, *Burden of Proof Begone: The Pernicious Effect of Emergency Removals in Child Protection Proceedings*, 41 FAM. CT. REV. 457, 459 (2003) (describing CPS agencies overresponding to highly publicized tragedies or operating based on fear of liability).
 152. Melissa Breger, *Making Waves or Keeping the Calm?: Analyzing the Institutional Culture of Family Courts Through the Lens of Social Psychology Groupthink Theory*, 34 L. & PSYCHOL. REV. 55, 78–79 (2010).
 153. See Garrison, *supra* note 129. See also LINDSEY, *supra* note 17, at 40 n.21 (“[C]hild welfare had not built an empirically validated knowledge base . . .”); *id.* at 168 (discussing child welfare’s inadequate knowledge base in assessing the need for in-home versus out-of-home care); Edward Zigler, *Controlling Child Abuse in America: An Effort Doomed to Failure*, in CHILD ABUSE AND VIOLENCE 39 (David G. Gil ed., 1979) (calling for “the development of the knowledge base that is a prerequisite for cost-effective interventions”).
 154. CHILD EXPOSURE TO TRAUMA: COMPARATIVE EFFECTIVENESS OF INTERVENTIONS ADDRESSING MALTREATMENT 15–16, U.S. DEP’T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RES. & QUALITY (2013), available at <http://effectivehealthcare.ahrq.gov/ehc/products/298/1463/trauma-interventions-maltreatment-child-executive-130415.pdf>.
 155. Jonathon Todres, *Addressing Public Health Strategies for Advancing Child Protection: Human Trafficking as a Case Study*, 21 J.L. & POL’Y 93, 103 (2012); WULCZYN ET AL., *supra* note 113, at 43.
 156. For summaries of primary, secondary, and tertiary prevention, see SCHNEIDER, *supra* note 123, at 12; TURNOCK, *supra* note 123, at 112–14.
 157. SCHNEIDER, *supra* note 123, at 12.
 158. James Garbarino, *The Emotionally Battered Child*, in C. HENRY KEMPE: A 50 YEAR LEGACY TO THE FIELD OF CHILD ABUSE AND NEGLECT, *supra* note 16, at 57, 59.

is that further episodes of maltreatment can be prevented, that less serious instances demand some effective intervention "before [they] advance[] to serious consequences,"¹⁵⁹ and, by implication, that prevention services rather than invasive government actions are often the best responses to acts of maltreatment.

Fifth, a public health approach offers a continuum of interventions based on the severity of the child maltreatment at issue, and it applies invasive and coercive interventions only when necessary. This element is consistent with existing practice—at least as described—which calls for meaningful services to be offered to families before removal occurs.¹⁶⁰ Responding to physical abuse that has caused an injury requiring medical attention requires a different and more invasive form of tertiary prevention than responding to a child's behavioral problems that result from his mother's neglect as his mother deals with an untreated mental health condition. Because the goal is to "minimize disability"¹⁶¹ and prevent or reduce harm as much as possible,¹⁶² an intervention that is itself harmful—such as removing a child from his home—is only indicated when the likely harm of staying in the home is greater than the harm from the removal. This analysis is analogous to the medical maxim of "do no harm"—or, at least, analogous with the goal of choosing an intervention that causes the least amount of harm possible.¹⁶³

A public health approach would complement, not contradict, the legal rights focus of child custody disputes—that is, that a parent has a right to custody of his or her child until the parent is proven unfit or otherwise at fault. Indeed, a public health model is infused with the values of the traditional rights model: the latter values children's and parents' right to family integrity and seeks to balance that right with the need for state intervention to protect children against familial abuse.¹⁶⁴ The value of a contextual view of children is that it can more accurately weigh the value of a child's relationship with her parents and, secondarily, other key figures in her life. Such valuation should limit state removals of children—because it will only be justified when the harm of removing the child is less than the harm the child endured in her environment and when no less invasive creative solution based on the full context of her life is viable. A public health analysis thus maximizes children's and parents' liberty because it lim-

159. Webster, *supra* note 120, at 1282.

160. See *supra* notes 42–43 and accompanying text.

161. SCHNEIDER, *supra* note 123, at 12.

162. Todres, *supra* note 144, at 453.

163. Albert J. Solnit, *Child Abuse: Least Harmful, Most Protective Intervention*, 65 PEDIATRICS 170, 171 (1980).

164. See *id.* (imposing the "least harmful" intervention is "compatible . . . with the constitutional model of maximizing the autonomy of parents and minimizing the intrusions into family privacy").

its unnecessary state coercion and maximizes the state's ability to protect children by more effectively preventing abuse and neglect and because it frees CPS agencies to focus on the most severe forms of maltreatment. That is, a public health approach better reflects the constitutional values inherent in the traditional rights model.¹⁶⁵

This complementary view is at odds with some in the field. Barbara Bennett Woodhouse advocates an “environmentalist paradigm” focusing on the full context of a child “rather than the child/parent/state triangle reflected in constitutional doctrine.”¹⁶⁶ She summarizes her proposed paradigm in language consistent with this Article’s: “Protecting endangered children requires us to see them not only as persons in their own right but also components in the inter-linked web of nature.”¹⁶⁷ Woodhouse then asserts that such contextual understanding of children “involves rejecting” a paradigm that views children and families “primarily in terms of individual rights.”¹⁶⁸ But it is not clear why such rejection is required. Woodhouse posits that an ecological model would not seek to terminate parental rights of a teenager who has a functioning, even if state-created, “ecosystem” of a stable foster home willing to keep him until he is an adult and a parent who visits regularly and to whom he is bonded.¹⁶⁹ This example poorly illustrates rejecting a rights-based approach because the courts have already significantly shuffled legal rights regarding the child—the parent and child lost the right to live together, and the state gained the right to place the child in a foster home. A rights-based model should reach the same result—the child has a right to a relationship with his mother, however flawed she may be, unless strong evidence can show why she is unfit and why terminating the mother-child relationship is in the child’s best interests, considering the child in his full ecosystem.

165. This view is similar to that of scholars like Clare Huntington, who argued that a rights framework is important but that it should be shifted “to the background (although not out of the picture entirely) in favor of a holistic, problem-solving model.” Clare Huntington, *Rights Myopia in Child Welfare*, 53 UCLA L. REV. 637, 641 (2006).

166. Woodhouse, *supra* note 11, at 412 (internal quotations omitted).

167. *Id.* at 434.

168. *Id.* Others criticize the existing rights triad, though they frame their prescriptions as additions to rather than replacements for that triad. For example, Sasha Coupet argues that the legal rights framework should recognize the rights of significant adult caretakers who are not parents. Sasha Coupet, *Neither Dyad nor Triad: Children’s Relationship Interests within Kinship Caregiving Families*, 41 U. MICH. J.L. REFORM 77, 85 (2007).

169. Woodhouse, *supra* note 11, at 443–44.

III. LIMITING THE COERCIVE INTERVENTION BY REFORMING REPORTING AND INVESTIGATION LAWS

Legal reforms to create a public health approach should begin by limiting the scope of the present invasive and coercive child protection system and, conversely, expanding options for providing services through more voluntary programs. These steps will apply the parental-fault paradigm to a narrower range of cases, those in which the severity of abuse or neglect or harm to a child necessitates such an approach, and will thus enable child protection agencies to focus more effectively on those cases while reducing legal barriers to other institutions serving other families more effectively.

This section addresses two legal pillars of the current system that require reform: mandatory reporting and mandatory investigation statutes that, on their own and, especially, in conjunction, inhibit a public health approach by directing millions of families to a coercive and ineffective system and blocking a more nuanced approach.

Consider a 13-year-old child attending the sixth grade in an urban middle school. The child has been held back once already, performs academically at the fourth grade, and frequently misbehaves, leading to multiple detentions and one- to five-day suspensions. The child lives with her mother, who has just lost her job. The family's home is their third in two years. Since the child's father was incarcerated three years ago, the family's income has declined, and they have not been able to keep up on rent. A school social worker calls home to tell the child's mother of her latest suspension and convinces the mother to come into the school for a meeting to address the child's behavior. At the meeting, the social worker observes what she thinks are symptoms of clinical depression from the mother. The mother says to her daughter, "I don't know what to do. You keep doing this, you keep getting whuppings, and you keep doing it again. I guess I'll have to whup you harder." The social worker later talks to the child, who says that a "whupping" involves being hit on the buttocks by a belt or extension cord. The child says, "It's OK. She only does it when I'm bad." She says she does not know if the whuppings leave marks and that the whuppings hurt while they happen but not afterwards. The social worker is concerned about more corporal punishment due to the child's school punishment and that the mother's possible depression could prevent her from dealing as effectively as possible with the child's behavior problems.¹⁷⁰

Under the current paradigm, this situation may trigger a call to the child protection hotline by the school social worker and an investi-

170. This hypothetical is a composite case of teenage clients whom I have represented over the years, coupled with incidents relayed to me from staff at various schools and child protective social workers.

gation by the child welfare agency. The child is unlikely to be removed from the home due to the lack of any present injury on the child, and the abuse allegation may not even be substantiated. As we know from data discussed above, the family's situation is unlikely to be helped by the child welfare system's involvement. This section will argue that the status quo is the antithesis of a public health approach because it calls a family to the attention of the wrong agency, which will invade the family's privacy and not help the family. Moreover, the status quo impedes those individuals and entities that could do something more effective and fulfill public health's preventative goals. Advocates for a public health approach have explicitly called for a better "balance" between CPS responses to child maltreatment and actions by a variety of professionals and community members with the ability to help children and families.¹⁷¹ But our child welfare system cannot establish such a balance when the law frames every reasonable suspicion of abuse or neglect as grounds for CPS intervention.

Accordingly, this section recommends reforms to both mandatory reporting statutes and mandatory investigation statutes and recommends the establishment of voluntary pathways to offering assistance to vulnerable families that do not pose a significant risk to their children's safety.

A. Mandatory Reporting Statutes

The present child welfare parental-fault paradigm and mandatory reporting laws were developed for the worst cases—parents who severely abuse their children. Legal reforms to promote a public health approach would repeal those laws or greatly narrow their scope.

Dr. C. Henry Kempe identified "battered child syndrome" in 1962, and his research and public policy responses have largely shaped our modern child welfare system, especially its present focus on individual bad actors whose pathologies, rather than social problems, lead them to abuse children.¹⁷² Kempe and his colleagues' writing served to articulate many of the key elements of the child welfare system that remain to this day—especially mandatory reporting statutes and thorough investigations of all reports of child maltreatment.¹⁷³ In one of the swiftest adoptions of significant social reform in American his-

171. Zimmerman & Mercy, *supra* note 129, at 6.

172. WALDFOGEL, *supra* note 118, at 139; MURRAY LEVINE ET AL., *THE IMPACT OF MANDATED REPORTING ON THE THERAPEUTIC PROCESS: PICKING UP THE PIECES* 5 (1995). For a narrative of Kempe's work and impact, see Hafemeister, *supra* note 49, at 838–41.

173. See M.G. Paulsen, *The Law and Abused Children*, in *THE BATTERED CHILD* 153, 162–73 (Ray E. Helfer & C. Henry Kempe eds., 2d ed. 1972) (positively describing the mandatory reporting and investigation structures that became the norm by the 1970s).

tory, every state adopted mandatory reporting statutes within five years of Dr. Kempe's first battered child syndrome article.¹⁷⁴ They now require a wide swath of professionals and, in eighteen states, all people, to report to CPS any time they have reasonable suspicion that a parent has abused or neglected a child.¹⁷⁵

Strikingly, Kempe and his colleagues advocated for narrower laws than soon became the national norm. For instance, they advocated that mandatory reporting should be limited to physicians, who would be the professionals most likely to encounter children suffering from severe physical abuse.¹⁷⁶ And physicians would likely only need to report serious injuries that the doctor concluded were not likely accidental; they reasoned that reporting other injuries would be an "uneconomic" use of child protection resources.¹⁷⁷ Their goal was to identify the most severe forms of child abuse, which they anticipated would number in the thousands.¹⁷⁸ The parental-fault paradigm inherent in the mandatory reporting and investigating laws advocated by Kempe and his allies makes sense for these severe cases. By enacting a mandatory reporting requirement as a condition for federal funding, Congress followed Kempe's focus on the most severe cases. Congress imposed reporting and investigation requirements in the most severe cases and did not develop a comprehensive treatment system.¹⁷⁹ State laws soon expanded, however, not only to include severe abuse, but also to require CPS reports whenever a mandatory reporter had a reasonable suspicion that any form of abuse or neglect had occurred.

174. Hafemeister, *supra* note 49, at 840.

175. *Id.* at 853–55. The present debate is at the margins—for instance, whether mediators in family court cases or social workers employed by lawyers ought to be covered by mandatory reporting statutes. Art Hinshaw, *Mediators as Mandatory Reporters of Child Abuse: Preserving Mediation's Core Values*, 34 FLA. ST. L. REV. 271 (2007); Alexis Anderson et al., *Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659, 690–717 (2006–07) (arguing for a mandatory reporter exception for social workers working for lawyers).

176. Paulsen, *supra* note 173, at 162.

177. *Id.* at 164.

178. In his 1962 paper, Kempe identified 302 "battered child syndrome" cases in hospitals and 447 in courts based on incomplete surveys. Kempe et al., *supra* note 15, at 17.

179. Susan Vivian Mangold, *Challenging the Parent-Child-State Triangle in Public Family Law: The Importance of Private Providers in the Dependency System*, 47 BUFF. L. REV. 1397, 1434 (1999).

Despite their omnipresent nature, their many supporters,¹⁸⁰ and their “sacrosanct” status,¹⁸¹ mandatory reporting laws have attracted criticism for many years from across the child welfare political spectrum, especially because of their strikingly broad scope.¹⁸² This American innovation has not spread far across the globe or even to all countries with similar legal systems. England, Scotland, and Wales have no mandatory reporting statutes, and Northern Ireland only requires reporting offenses which might lead to arrest—a narrower range than the American requirement of reporting reasonable suspicion of any form of child maltreatment, even that which does not qualify as a crime.¹⁸³ Comparisons with those countries suggests little reason to believe that mandatory reporting helps authorities identify a higher rate of the most severe cases or that it increases child safety outcomes.¹⁸⁴

The most damning critique of mandatory reporting is from Gary Melton, who collects research showing that professionals who could refer families to various support services did not do so when they were subject to mandatory reporting statutes and, instead, only analyzed whether those statutes applied.¹⁸⁵ That analysis may lead them to report or not—there is significant evidence that many choose not to report, perhaps as many as choose to report¹⁸⁶—and that choice seems to be all that happens in far too many cases. More anecdotal studies also find that nonprofessionals often decline to report suspected problems because they do not trust that child protection agen-

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180. *E.g.*, Ben Mathews & Donald C. Bross, *Mandated Reporting Is Still a Policy with Reason: Empirical Evidence and Philosophical Grounds*, 32 *CHILD ABUSE & NEGLECT* 511 (2008); Brett Drake & Melissa Jonson-Reid, *Commentary, A Response to Melton Based on the Best Available Data*, 31 *CHILD ABUSE & NEGLECT* 343 (2007).
 181. Melton, *supra* note 13, at 16. Richard Gelles also uses religious imagery, describing criticism of mandatory reporting as “heretical.” RICHARD GELLES, *THE BOOK OF DAVID* 154 (1996).
 182. For a summary of critiques, see SETH C. KALICHMAN, *MANDATED REPORTING OF SUSPECTED CHILD ABUSE: ETHICS, LAW, & POLICY* 30–33 (2d ed. 1999).
 183. WALLACE & BUNTING, *supra* note 20, at 4. Wallace and Bunting found “few countries” to have mandatory reporting statutes, and some of those countries have statutes with a narrower scope than American laws. *Id.* at 4–5.
 184. Comparing the United States and Britain, Jane Waldfogel found that the primary difference was that more reports of less severe neglect cases were made in the United States and that, despite this relatively high level of reports, children suffered less repeat maltreatment in Britain. WALDFOGEL, *supra* note 118, at 64.
 185. Melton, *supra* note 13, at 14.
 186. The federal government estimates that mandatory reporters are aware of, but do not report, most of the uninvestigated maltreatment, which accounts for a majority of all maltreated children. NIS-4, *supra* note 79, at 8–21. Even the eighteen states that make every adult a mandatory reporter do not have increased rates of child protection reports. REBECCA McELROY, *FIRST FOCUS, AN ANALYSIS OF STATE LAWS REGARDING MANDATED REPORTING OF CHILD MALTREATMENT* 3, <http://www.firstfocus.net/sites/default/files/An%20Analysis%20of%20State%20Laws%20Regarding%20Mandated%20Reporting%20of%20Child%20Maltreatment.pdf>.

cies will provide appropriately supportive responses.¹⁸⁷ Relatedly, Melton argues that mandatory reporting statutes give those who call the hotline the false impression that they have done all they can for the child and that child protection authorities will be able to monitor families, thus deterring these individuals from pursuing potentially more helpful interventions.¹⁸⁸

Critics have also worried that the possibility of mandatory reporting “probably deters many families from seeking help” and disrupts families’ participation in treatment.¹⁸⁹ Treatment disruptions are particularly evident with mental health care; one study reported that 24% of clients stopped treatment after a report by their treatment provider and that the rate was 31% when the clients themselves were the alleged maltreater,¹⁹⁰ and another reported a decrease in clients’ disclosures of abuse following enactment of mandatory reporting statutes. These disruptions make it more difficult to provide treatments to prevent further abuse.¹⁹¹ A report by the National Center on Substance Abuse and Child Welfare concluded that “fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use” is “[o]ne key reason” too few women receive pre-natal care.¹⁹² Mandatory reporting also breaks

187. Dorothy Roberts interviewed twenty-five women in a largely black Chicago neighborhood in which a disproportionate number of families were involved with the local child protection agency. One such woman explained why she would not call the agency about a friend of hers with a substance-abuse problem, even though she acknowledged that the friend ought to get into treatment and needed help with her young children: “It would be on my conscience knowing that I made this phone call and this girl probably never see her kids.” Roberts, *supra* note 28, at 130–32.

188. Melton, *supra* 13, at 13.

189. *Id.* at 14.

190. Holly Watson & Murray Levine, *Psychotherapy and Mandated Reporting of Child Abuse*, 59 AM. J. ORTHOPSYCHIATRY 246, 252–53 (1989). Watson and Levine oddly characterize their results as showing that mandatory reporting does not disrupt treatment and that fears of the contrary are “unfounded.” *Id.* at 252. Yet they acknowledge that a “significant minority” of clients do stop treatment, *id.* at 253, and that other factors, such as court orders to remain in treatment or fear of CPS agencies’ responses to stop treatment, might explain why even more clients did not stop. *Id.* at 254. And Watson and Levine concede that they saw no data showing that such hotline calls served to protect children or that CPS even followed up with the therapist in most cases—that is, there was no documented positive effect to counterbalance the documented negative effects. *Id.* at 254.

191. *Id.* (citing Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449, 449–53 (1991)); see also KALICHMAN, *supra* note 182, at 58–59 (describing studies showing how mandatory reporting statutes could decrease disclosures of past sexual abuse by abusers seeking treatment in some clinical settings and studies showing no effect in other settings).

192. SCREENING & ASSESSMENT FOR FAMILY ENGAGEMENT, RETENTION, AND RECOVERY (SAFERR), C-8, U.S. DEP’T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE &

the confidentiality between a professional and a client, creating ethical dilemmas for many reporters¹⁹³ and deterring reporting.

Even some advocates for more coercive government action see mandatory reporting laws as counter-productive. Consider Richard Gelles, a critic of family preservation services and a lead proponent of the Adoption of Safe Families Act, which increased the number of termination of parental rights cases and reduced the obligations on states to make efforts to keep families together.¹⁹⁴ Gelles argued as early as 1996 that we should “eliminate mandatory reporting” because it leads to disproportionately high reports regarding poor and minority families and because it “has overwhelmed the child protection system to the point that it can barely conduct investigations and rarely deliver meaningful and effective services.”¹⁹⁵ Importantly for this Article’s purposes, Gelles recognizes that mandatory reporting requirements wrongly assume that the wide swath of professionals whom they affect lack the desire or ability to address child maltreatment.¹⁹⁶

Mandatory reporting statutes not only create the harms identified by Gelles and Melton but prevent a more effective public health response from taking shape. Mandatory reporting laws direct the people best suited to address a situation that they cannot and should not address it but should simply call it in. One example is drug and alcohol abuse by pregnant women. The American College of Obstetricians and Gynecologists has urged universal screening and referral to help women recover from their addictions and emphasizes that a “climate of respect and trust” between physician and patient rather than actions that “stigmatize” women is essential to intervening effectively. Mandatory reporting laws create a “difficult dilemma” because they erode confidentiality and trust and may deter women from disclosing substance-abuse problems or prevent doctors from intervening effec-

MENTAL HEALTH SERVS. ADMIN. (2004), available at <http://www.ncsacw.samhsa.gov/files/SAFERR.pdf>.

193. E.g., Kenneth J. Lau et al., MANDATED REPORTING OF CHILD ABUSE AND NEGLECT: A PRACTICAL GUIDE FOR SOCIAL WORKERS 159–79 (2009) (devoting a chapter to the “legal and ethical issues in mandated reporting”).
194. See FRONTLINE, *Interview: Richard Gelles*, <http://www.pbs.org/wgbh/pages/frontline/shows/fostercare/inside/gelles.html> (last visited Aug. 2, 2013) (describing Gelles as a drafter of the Adoption and Safe Families Act and an advocate of removing more children from families).
195. GELLES, *supra* note 181, at 153–55. Other scholars articulate a similar concern. E.g., Michael S. Wald, *Preventing Maltreatment or Promoting Positive Development—Where Should a Community Focus Its Resources?*, in PREVENTING CHILD MALTREATMENT, *supra* note 47, at 182, 192–93; Don Duquette, *Looking Ahead: A Personal Vision of the Future of Child Welfare Law*, 41 U. MICH. J.L. REFORM 317, 334 (2007).
196. GELLES, *supra*, note 181, at 154.

tively.¹⁹⁷ As a result, mandatory reporting laws likely induce a reduction in the frequency of screenings of pregnant women for drug use.¹⁹⁸ Even when physicians seek to use screening and referral protocols to help patients in a respectful and collaborative way, those actions “may be perceived as punitive measures when they are connected with legally mandated testing, or reporting.”¹⁹⁹

Seth Kalichman has identified several public health goals that mandatory reporting is supposed to achieve; they aim to “restore family competence and eliminate maltreatment” and “provide or refer families for mental health services.”²⁰⁰ But it should be evident that these goals have not been achieved in practice. As noted above, the status quo has not led toward improved family competencies, even when solvable problems are identified; helpful services are simply not provided in significant numbers.²⁰¹ Logically, the connection between mandatory reporting laws and referrals for services is tenuous because the professionals subject to those laws could be capable of making such referrals without reporting the family to CPS authorities. Indeed, Kalichman’s suggestion that mandatory reporting exists as a means to obtain services for families shows, at the very least, that reporting introduces a middleman. Rather than make service referrals themselves, professionals rely on CPS agencies to do so. Even if a middleman is necessary, Kalichman’s suggestion does not explain why CPS must be the middleman. If the goal is service referral, a public health hotline could do the job as easily as a child protection hotline. This reliance only triggers the harms of CPS responses to hotline calls—invasive investigations and the threat of child protection registry listings and child removals—a high price to pay for service referrals. The reliance also illustrates how mandatory reporting impedes frontline service providers from making service referrals.

Even more deeply, mandatory reporting statutes impede a public health approach because they occupy the field of professionals’ response to possible child maltreatment. When calling the hotline is “society’s primary, and arguably only, means of identifying and responding to child abuse,”²⁰² mandatory reporting statutes leave the professionals who could provide a public health response with little

197. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS COMMITTEE OPINION NO. 422, AT-RISK DRINKING AND ILLICIT DRUG USE: ETHICAL ISSUES IN OBSTETRIC AND GYNECOLOGIC PRACTICE 5 (2008), available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Ethics/co422.pdf?dmc=1&ts=20120531T1247428368> [hereinafter ACOG OPINION 422].

198. James G. Dwyer, *The Child Protection Pretense: States: Continued Consignment of Newborn Babies to Unfit Parents*, 93 MINN. L. REV. 407, 445 (2008).

199. ACOG OPINION 422, *supra* note 197 at 6.

200. KALICHMAN, *supra* note 182, at 98–99.

201. *Supra* notes 112–18 and accompanying text.

202. Hafemeister, *supra* note 49, at 903.

space to do so; they either call the hotline and trigger a coercive CPS intervention, or they decide to not make a call, violating the mandatory reporting statute. Efforts to engage other service providers to work with a family cannot be done without risking that one of those providers will call the hotline; any service provider's efforts to build trust are undermined by that provider's simultaneous duty to report suspected maltreatment.²⁰³ In extreme cases, a homeless family merely asking for help in obtaining housing has triggered child protection hotline calls.²⁰⁴

Consider the hypothetical described at the top of Part II. The school social worker surely has reasonable suspicion that the child's mother will abuse her—in part because, as discussed in section II.C, abuse and neglect statutes broadly define those concepts to include physical discipline with objects, including actions that may leave a mark. Thus, mandatory reporting statutes are triggered. If the social worker follows the law and calls the hotline, then her relationship with the child and family will likely change because she reported them.²⁰⁵ The parent will feel betrayed by the social worker and perhaps the school, making it more difficult, if not impossible, for anyone at the school to suggest actions that the child's mother can take to help her daughter, to talk with the mother about the various stressors in her life, or to help the mother address those stressors.²⁰⁶ If the social worker wants to disregard the law and try to find appropriate services for the family, it is not clear who else she can call except for the child protection agency; no other public hotline exists that can provide a range of voluntary services for a troubled family.

Reporting suspected child abuse or neglect could also have positive effects in a reporter's relationship with a client; it could validate a child client's report of abuse by an adult and, of course, help protect

203. Doriane Lambelet Coleman, *Innovations in Child Maltreatment Prevention: Resolving the Tension between Effective Assistance and Violations of Privacy*, in PREVENTING CHILD MALTREATMENT, *supra* note 47, at 156, 168.

204. Annie Gowen, "Heart-wrenching" Catch-22: Homeless Families Who Turn to City for Help Find No Rooms, *Risk Child Welfare Inquiry*, WASH. POST, June 23, 2012, http://www.washingtonpost.com/local/homeless-families-who-turn-to-dc-for-help-find-no-room-risk-child-welfare-inquiry/2012/06/23/gJQAv9bJyV_story.html.

205. The school social worker will, in theory, remain anonymous. *E.g.*, CAL. PEN. CODE § 11167 (d)(1). But, in practice, it is not difficult to determine who made a hotline call from the timing of the ensuing investigation and the investigator's questions.

206. One immigrant parent articulated this sense of betrayal: "In my country the teacher is the person with the power and has a right to speak. The parents respect the teacher to tell them what is going on—here, they [the teachers] talk behind your back to the government and you the parents are without any power." Ilze Earner, *Immigrant Families and Public Child Welfare: Barriers to Services and Approaches for Change*, 86 CHILD WELFARE 63, 80 (2007).

children from future abuse.²⁰⁷ Engaging the coercive power of the law can, in some cases, help clients admit abuse and work to avoid repeating past misdeeds.²⁰⁸ But these positive effects do not result from the law mandating reporting. Laying responsibility for a report on mandatory reporting laws does not help clinicians develop stronger therapeutic relationships.²⁰⁹ Rather, these positive effects require the use of professional discretion that mandatory reporting laws outlaw.²¹⁰ For instance, making a CPS report is most likely effective to treatment when the alleged maltreater was not the child's parents; in such cases, parents and children tended to view reports as validating their concerns and protecting them.²¹¹ In contrast, when the client is the person alleged to have maltreated a child, the likelihood that the client would leave treatment—thus possibly endangering children—increases.²¹²

Mandatory reporting statutes have long been animated by the idea that legally requiring child abuse and neglect reporting is necessary to ensure that professionals do not turn a blind eye to abuse or neglect; Ben Mathews and Donald Bross, for instance, argue that mandatory reporting ensures that authorities identify a higher rate of abuse and neglect than in jurisdictions without such reporting.²¹³ Such statistics, however, do not establish the marginal effect of mandatory reporting. Jane Walfogel's comparison of the United States and Britain (which does not have mandatory reporting) found that this relatively high level of reports did *not* lead to better child safety outcomes; if anything, children suffered less repeat maltreatment in Britain, which is without mandatory reporting.²¹⁴ Similarly, Duncan Lindsey has concluded that years of data establish that increasing reporting does not lead to fewer child fatalities.²¹⁵ These results should not be surprising. Unlike a half century ago when mandatory reporting statutes were first enacted, professional awareness of the most severe kinds of maltreatment has significantly increased, and key professions have institutionalized a focus on maltreatment. For instance, children's hospitals now frequently have child protection centers de-

207. LEVINE, *supra* note 172, at 119–29; Kalichman, *supra* note 182, at 99.

208. KALICHMAN, *supra* note 182, at 99–100.

209. LEVINE, *supra* note 172, at 104–05.

210. *Id.* at 142–44 (arguing for discretionary reporting); *see also* KALICHMAN, *supra* note 182, at 102–03 (listing criteria like “gain acceptance for reporting” and “gain consent for reporting” as part of “therapeutically applying mandatory reporting laws”—even though such steps are not possible in all cases).

211. LEVINE, *supra* note 172, at 79.

212. *Id.*

213. Mathew & Bross, *supra* note 180, at 512 (comparing substantiated abuse and neglect rates in England and western Australia with rates in Canada, the United States, and other Australian jurisdictions).

214. WALDFOGEL, *supra* note 118, at 64.

215. LINDSEY, *supra* note 17, at 137–38.

signed to identify injuries most likely caused by abuse.²¹⁶ Instead of protecting children from the most severe forms of abuse, therefore, mandatory reporting statutes serve to widen the scope of CPS involvement in less serious cases and prevent the use of less coercive interventions in those cases.

B. Mandatory Investigation Statutes and the Trend Toward Differential Response

It is not only the existence of mandatory reporting statutes and the immense number of resulting calls, but also child protection agencies' legally required response to such calls that undermines a public health approach. In most jurisdictions, the school social worker's call will automatically trigger a child protection investigation because most state statutes require child welfare agencies to investigate every allegation of abuse or neglect.²¹⁷ These investigations are hallmarks of a parental-fault paradigm—coercive actions that seek to determine if a parent has committed a particular bad act. As discussed above, these investigations impose harms in their own right, invading children's and parents' privacy, causing anxiety and other emotional harms on children, and limiting families' economic security and opportunities by placing parents on child protection registries. In communities in which child protection agencies have particularly large impacts, child protection investigations may become weapons in personal conflicts, as neighbors may trigger investigations by alleging child maltreatment.²¹⁸ Beyond the invasiveness of the resulting investigations, this phenomenon can increase tensions among neighbors,²¹⁹ which may weaken the communal bonds that could provide a crucial form of private support for many families. They may contribute to a generalized weakening of parental authority over their children;²²⁰ when a stranger comes to a home, inspects every room against a parent's wishes, asks the parents personal questions, and insists on interviewing children alone, it teaches children that their

216. *E.g.*, Children's Nat'l Medical Center, CHILD AND ADOLESCENT PROTECTION CENTER, <http://www.childreinsnational.org/departmentsandprograms/default.aspx?Id=371&Type=Dept&Name=Child%20and%20Adolescent%20Protection%20Center> (last visited Aug. 2, 2013).

217. *E.g.*, TEX. FAM. CODE ANN. § 261.301(a) (West 2008) (“[T]he [child welfare] department or designated agency shall make a prompt and thorough investigation of a report of child abuse or neglect . . .”).

218. Roberts, *supra* note 28, at 138–41. Jane Waldfogel found a large “extent to which the system seems to be used for family and other quarrels” without much evidence of maltreatment. WALDFOGEL, *supra* note 118, at 19.

219. Roberts, *supra* note 28, at 138–41.

220. Ruth Lawrence-Karski, *United States: California's Reporting System*, in COMBATING CHILD ABUSE: INTERNATIONAL PERSPECTIVES AND TRENDS 31–32 (Neil Gilbert ed., 1997) (quoting Albert J. Solnit, *Children, Parents and the State*, 52 AM. J. ORTHOPSYCHIATRY 496, 501–02 (1982)).

parents' authority is far from absolute. Coupled with the anxiety produced by such invasions,²²¹ we should expect that CPS investigations will often trigger discipline problems among many affected children.

Child welfare law has gradually begun to acknowledge these harms, as at least eighteen states have implemented "alternative response" or differential response programs.²²² As the name suggests, these programs direct child welfare authorities to respond to different types of child abuse and neglect reports differently. A report that an infant has suffered injuries that a physician believes were likely caused by abuse rather than an accident will be investigated, while a report from the school social worker would trigger an assessment of the family's needs and an offer of services. Differential response begins with a legal change; in place of mandatory investigation laws, legislatures give child protection agencies the choice of how to respond to abuse or neglect reports—with a traditional investigation or a family assessment.²²³

This legal reform is striking for stepping away from a parental-fault model and toward a public health model. No investigation occurs, so there is no designation of a parent who is at fault and no placement of a parent on the child protection registry. They are designed to focus government assessments on a family's full range of needs rather than determining whether a particular incident occurred as alleged and whether it rises to the level of abuse or neglect. Family assessments and subsequent services are voluntary and less stigmatizing than a finding of abuse or neglect. Unsurprisingly, the result is that families are more likely to participate in services, develop stronger relationships with social workers, and believe that child welfare agencies treated them fairly.²²⁴ The government is also able to provide services to families faster²²⁵—perhaps because the families are more cooperative or perhaps because the government does not first take time to document parental fault before arranging for services. As a result, the less invasive approach of differential response appears to help children remain safer than a more invasive investigation. Several states implementing differential response showed better child

221. GOLDSTEIN ET AL., *supra* note 100, at 97.

222. CHILD MALTREATMENT 2011, *supra* note 45, at 18.

223. *E.g.*, Families Together Amendment Act of 2010, D.C. Law 18-228, amending D.C. CODE § 4-1301.04, available at <http://dclims1.dccouncil.us/images/00001/20100624152836.pdf> (last visited Aug. 2, 2013). In full disclosure, I advocated for this bill's passage and contributed to its drafting.

224. DIFFERENTIAL RESPONSE, *supra* note 14, at 12–13 (collecting research).

225. In Missouri, for instance, assessment track families received services in an average of seventeen days while investigation track families did so within thirty-five days. Gary L. Siegel & L. Anthony Loman, *The Missouri Family Assessment and Response Demonstration Impact Evaluation: Digest of Findings and Conclusions*, INST. OF APPLIED RES. 16 (2000), <http://www.iarstl.org/papers/MoFamAssess.pdf>.

safety outcomes than with investigations,²²⁶ and the worst outcomes in studies show that differential response has not reduced child safety outcomes at all.²²⁷

One should not conclude, however, that differential response fully addresses the need for a public health approach to child welfare. First, the approach is still in its infancy. The most recent federal data shows only eighteen states implementing it, accounting for only 9.8% of responses to child protection calls across the country.²²⁸ Moreover, there is little uniformity in approach; for instance, some states apply differential response for children of all ages, some still require investigations for all allegations involving young children, some focus differential response on cases involving domestic violence between adults, and some explicitly exclude such cases from differential response programs.²²⁹

More fundamentally, differential response may be a less dramatic change in practice than it promises in the abstract. In some states, the same workers perform both investigations and assessments, and, not surprisingly, many of these workers perform the same actions in both categories.²³⁰ Differential response still filters cases through child protection agencies—families must first be reported to CPS agencies, and CPS agencies handle the response. As a result, entities like schools remain unlikely to implement a public health approach and instead would remain likely to simply call in concerns. CPS agencies' responses maintain a coercive element that is not necessary in cases that are largely about providing effective and voluntary ser-

226. DIFFERENTIAL RESPONSE, *supra* note 14, at 9 (“[D]ifferential response systems have demonstrated positive outcomes, particularly in terms of sustained child safety”); Gary L. Siegel & Tony Loman, *Extended Follow-Up Study of Minnesota’s Family Assessment Response*, INST. OF APPLIED RES. 5, 27–30, 42–44 (2006), <http://iarstl.org/papers/FinalMNFARReport.pdf> (finding that differential response led to reduced recidivism and fewer removals of children from their families); L. Anthony Loman & Gary L. Siegel, *Differential Response in Missouri After Five Years*, INST. OF APPLIED RES. 2, 8–9 (2004), <http://www.iarstl.org/papers/MODiffResp2004a.pdf> (finding improved child safety outcomes through differential response and fewer repeat CPS hotline reports for families receiving a differential response than similar families who were investigated); Lisa Merkel-Holguin et al., *National Study on Differential Response in Child Welfare*, AM. HUMANE ASS’N 37 (2006), <http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf> (finding that in Kentucky, “[c]ases within the investigative track were twice as likely to have a subsequent investigation with 3 percent [of differential response families] and 5.8 percent of investigations cases having an investigation within Time #2”).

227. DIFFERENTIAL RESPONSE, *supra* note 14, at 11.

228. CHILD MALTREATMENT 2011, *supra* note 45, at 17.

229. Cynthia Godsoe, *Just Intervention: Differential Response in Child Protection*, 21 J.L. & POL’Y 73, 79–80 (2012–2013).

230. Waldfoegel, *supra* note 81, at 144.

vices.²³¹ Even though differential response services are formally voluntary, and some data suggests that agencies rarely turn differential response cases into adversarial investigations or removals,²³² implicit coercion remains. When a child welfare agency official comes to a home to say, “We received a hotline call, and we’d like to help,” it is not hard to imagine many if not most families believing that negative consequences will flow from a decision to not cooperate.²³³ A less invasive structure would have a different agency—or perhaps a new agency staffed by public health nurses—offer services through a differential response system.

Minnesota has begun experimenting with a differential response structure along these lines, creating a Parent Support Outreach Program that takes two steps to separate its services from CPS.²³⁴ First, it permits any service providers to refer families directly to the program for assistance, and it permits families to refer themselves, bypassing a call to CPS.²³⁵ The program seems to have stumbled upon this CPS-bypass design; it originally only served those families subject to a screened-out report and was only broadened to include direct referrals by service providers and self-referrals when the pilot program did not receive sufficient referrals.²³⁶ Such families eventually became more than 45% of the program,²³⁷ which perhaps demonstrates a strong demand for such voluntary services. Second, in some counties, private nonprofits with state contracts operate the Parent Support Outreach Program, rather than direct employees of state or county agencies.²³⁸ An evaluation of this program found that the families at issue have multiple serious needs²³⁹ and that the voluntary

231. See Douglas J. Besharov with Lisa Laumann, *Child Abuse Reporting*, 33 *SOCIETY* 40, 44 (1996) (advocating limiting CPS responses to “situations in which the child is so endangered that social services must be forced upon unwilling parents” and not when a case involves a need to “provide[] services to families in trouble”).

232. See, e.g., Dep’t of Soc. Servs. Commonwealth of Va., *Evaluation of the Differential Response System*, Virginia Department of Soc. Services 12 (2008), http://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2008/differential_response_system_evaluation_annualreport_2008_12-08.pdf (reporting that only 2% of families referred to an assessment track were subsequently referred for an investigation). But see Godsoe, *supra* note 229, at 90–91.

233. See Godsoe, *supra* note 229 at 91 (asserting that when parents decline services in some jurisdictions, “they are switched to the investigation track, sometimes by agency or other mandates, and sometimes just by the common practice of caseworkers”).

234. See *id.* at 88–89.

235. Tony Loman et al., *Minnesota Parent Support Outreach Program Evaluation*, INST. OF APPLIED RES. 4, 1 (2009), <http://www.iarstl.org/papers/PSOPFinalReport.pdf> [hereinafter *Minnesota Evaluation*].

236. *Id.* at 4.

237. *Id.* at 5.

238. *Id.* at 11.

239. *Id.* at 35–38.

services arranged through the program led to significant improvement in these needs and reduced future reports to CPS.²⁴⁰ A key feature in this improvement was likely its separation from CPS agencies. Referrals that did not involve CPS and program outreach by contracted workers were more likely to lead to successful engagement with case managers, especially when families had a prior history with CPS and thus, perhaps, both a reason to distrust state agencies and reason for state agencies to suspect high maltreatment risks.²⁴¹

More study is needed; one should not read too much into the results of one program, especially when a key element of its design appears haphazard, and its evaluation lacked a control group.²⁴² But its positive results should come as no surprise and should spark more intentional and rigorous experimentation and study of voluntary child welfare services that avoid and even prevent CPS involvement. Not only should future studies include an experimental design, but they should also evaluate whether more positive results can be obtained by providing more services, such as the provision of legal services to families.²⁴³

C. Specific Reforms

The above analysis suggests several specific reforms to remove the barriers to a public health approach.

First, state and federal lawmakers should limit mandatory reporting statutes to cases involving severe abuse or neglect.²⁴⁴ Such reforms would encompass the more severe cases for which mandatory reporting statutes were drafted—cases of severe injuries from physical abuse or sexual abuse. This step would establish coherent lines between families that need voluntary services and those that need coercion—at least for the limited purpose of determining whether the alleged maltreatment occurred.

This approach does create a slippery slope risk, as legislators would face strong pressures to expand them to demonstrate that they are doing something in response to some future scandal or well-publicized tragedy. Indeed, that is precisely what happened in the 1970s, as growing awareness of child abuse and neglect pushed legislators to

240. *Id.* at xii, 67, 72, 89–90.

241. *Id.* at 14, 27. Contracted workers also referred families for more services than public employees did. *Id.* at 46.

242. *Id.* at 67.

243. *See infra* note 321 and accompanying text.

244. Some mandatory reporting statute is required for states to receive federal child welfare funding. 42 U.S.C. § 5106a(b)(2)(i) (Supp. V 2011). Federal law does not, however, specify which abuse or neglect must be reported, the level of suspicion that must exist before reporting is required, or who must be deemed a mandatory reporter. *Id.* Thus, significant room for state innovation exists even without federal changes.

expand the scope of mandatory reporting statutes well beyond doctors.²⁴⁵ That slippery slope risk would counsel in favor of a more complete repeal of mandatory reporting statutes.

More modest reforms are possible, as well, and would be consistent with a public health approach. For instance, legislatures could permit mandatory reporters to fulfill their obligation by consulting with CPS authorities about the need for an investigation based on the facts of individual cases, without divulging identifying details.²⁴⁶ Alternatively, legislatures could require professionals to report concerns that a child is being abused or neglected but could provide those professionals with discretion regarding to whom they make a report. A school social worker addressing a child in a situation described above could then call either CPS or a voluntary program like the Parent Support Outreach Program piloted in Minnesota, thus ensuring some attention is paid to the family without immediately imposing a coercive and adversarial state response to such concerns.

Even with dramatically narrowed mandatory reporting statutes, we should expect large numbers of voluntary reports of child abuse and neglect to continue. None of these proposals would impede voluntary reports to child protection authorities; just as many individuals who are not mandatory reporters currently report suspected abuse or neglect to CPS, current mandatory reporters would (and should) also report many cases even if not legally required.

The second crucial reform is for states²⁴⁷ to limit child protection investigations to those reports alleging relatively severe abuse or neglect; less severe cases should trigger an offer to assess the family's need for services and arrange any indicated services, ideally by an agency or private organization that is separate from the child protection agency. Relatedly, courts should impose warrant and probable cause limitations on these investigations; these investigations are inherently invasive, and nonconsensual searches and seizures should only occur when the available evidence establishes probable cause of abuse or neglect and when the government's action satisfies the modest judicial check of a warrant procedure.²⁴⁸

Third, when CPS agencies substantiate allegations of abuse or neglect against a parent, they should place those parents on child protection registries only when that step serves the purpose of such registries—to protect other children from abuse or neglect, especially

245. Hafemeister, *supra* note 49, at 841–53.

246. Coleman, *supra* note 203, at 169.

247. Existing federal law encourages states to develop differential response systems and does not impose significant limits on how states can structure such programs. 42 U.S.C. § 5106a(a)(4), (a)(6), (a)(9), (a)(10), (a)(13), (a)(14), (b)(2)(B)(v) (Supp. V 2011).

248. Coleman, *supra* note 82, at 415–17; Gupta-Kagan, *supra* note 82, at 421–22.

from adults with certain jobs, such as teaching or bus driving. The most severe forms of abuse should lead to automatic registry placements; to take an easy case, child sex abusers should not be permitted to work in close proximity to children. But parents found to have committed less severe forms of maltreatment should not be placed on registries without some indication that they pose a risk to other children. Most parents should also have the opportunity to petition to be removed from registries after the passage of time or evidence of rehabilitation. Only a small minority of states has taken such steps, creating registry tiers based on the severity of the abuse or neglect that they substantiate.²⁴⁹ Those efforts would be made easier in practice if legal reforms led to more precise definitions of abuse and neglect.²⁵⁰ Alternatively, CPS agencies could perform risk assessments, hopefully developed to be statistically valid,²⁵¹ to determine which parents present a truly unacceptable risk to children such that they should be barred from employment with children.

IV. ESTABLISHING NARROWER DEFINITIONS OF ABUSE AND NEGLECT AND MORE CONSISTENT STANDARDS FOR THE MOST INVASIVE ACTIONS

Existing definitions of child abuse and neglect are overly broad, as critics have argued for more than three decades; Michael Wald criticized the then-relatively new child abuse and neglect laws in 1975 for their over breadth and proposed limiting them to more “realistic standards.”²⁵² Wald later served as a reporter of an American Bar Association effort to define child abuse and neglect definitions, which proposed relatively narrow grounds for court intervention. The ABA would have limited jurisdiction to cases involving an existing or “substantial risk” of a “serious physical injury,” “serious emotional damage” without treatment, sexual abuse, medical neglect risking “substantial impairment of bodily functions,” or parental encouragement of a child’s delinquent activity.²⁵³ Present law remains remarkably broad, especially in comparison to the ABA’s proposal. One state, for instance, defines abuse to include action causing “any physical injury”²⁵⁴ and permits state intervention whenever a child is “without

249. 16 DEL. CODE ANN. § 923 (2003); 325 ILL. COMP. STAT. ANN. § 5/7.14 (West 2005). In the majority of states, no such tiers exist. See generally U.S. DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILD. & FAMILIES, *supra* note 86.

250. *Infra* Part IV.

251. For a discussion of risk assessments in child welfare, see *infra* notes 268–273 and accompanying text.

252. Michael Wald, *State Intervention on Behalf of “Neglected” Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985, 985 (1975).

253. AMERICAN BAR ASSOCIATION, JUVENILE JUSTICE STANDARDS PROJECT: STANDARDS RELATING TO ABUSE AND NEGLECT 16–17 (1981).

254. MO. ANN. STAT. § 210.110(1) (West 2010).

proper care, custody or support.”²⁵⁵ Defining neglect remains extremely hard.²⁵⁶

A full accounting of the breadth of state laws and practices to define “abuse” and “neglect” has been covered before²⁵⁷ and is beyond the scope of this Article. This Article instead focuses on the effects of this breadth and vagueness, which contribute to existing law’s inhibition of a public health approach.

Operating in tandem with mandatory reporting and mandatory investigation statutes discussed in Part II, these vague definitions expand the scope of a number of coercive and invasive elements of our child welfare system. They trigger more people to make reports of suspected child abuse or neglect; mandatory reporter statutes are triggered whenever a reporter has reasonable suspicion of abuse or neglect,²⁵⁸ quite a low bar.²⁵⁹ By triggering more reports, these broad definitions trigger more CPS investigations, which trigger consideration of the most invasive option available—a court action and removal.²⁶⁰

Broad and vague definitions also permit remarkable inconsistency in child protection practice. Leading studies show only a “weak relationship” between the severity of abuse and the likelihood that authorities removed a child from an abusive family.²⁶¹ This conclusion is true even for sexual abuse cases, some of the most serious cases that the child protection system handles.²⁶²

The effect of the vague definitions is exacerbated by the wide discretion granted to courts to impose dispositions deemed to be in a child’s best interest. Finding any kind of child abuse or neglect places children and parents under a family court’s jurisdiction, and the court then can adopt whatever disposition the court finds to be in the child’s best interest.²⁶³ This decision is often based on child welfare agency

255. MO. ANN. STAT. § 211.031.1(b) (West 2010); *see also, e.g.*, COLO. REV. STAT. §§ 19-1-103, 19-3-102 (2013) (defining neglect as the absence of “proper parental care”); D.C. CODE § 16-2301(9)(A)(ii) (2001) (defining a neglected child as “without proper parental care or control”).

256. *E.g.*, Garbarino, *supra* note 158, at 59.

257. Wald, *supra*, note 78. For a more recent example, see Godsoe, *supra* note 19, at 123–24.

258. *E.g.* MO. ANN. STAT. § 210.115.1 (West 2010) (“reasonable cause”).

259. As important, definitions of abuse or neglect are understood in the nonlegal literature to be “broad” and “ambiguous,” ensuring a large number of reports as a result. Levine, *supra* note 172, at 15, 139.

260. Hafemeister, *supra* note 49, at 845.

261. LINDSEY, *supra* note 17, at 146.

262. *Id.*

263. *E.g.*, MO. ANN. STAT. § 211.181.1 (West 2010) (once it finds abuse or neglect, a court may enter any listed disposition); D.C. CODE § 16-2320(a) (2001) (noting that once a court finds abuse or neglect it can order “disposition[] which will be in the best interest of the child”). *But see* S.C. CODE ANN. § 63-7-1660(B), (E) (1976)

reports not tested through the rules of evidence and an adversarial trial.²⁶⁴ As a result, relatively minor cases can lead to foster care placement while more severe cases can lead to children remaining at home. Criminal law provides an illustrative comparison; it separates criminal conduct into multiple tiers depending on their severity—felonies, subdivided into class A, B, C, and so on, and misdemeanors—and sentencing guidelines provide a relatively narrow range of sentencing options in most cases. With narrow exceptions,²⁶⁵ child welfare law places all conduct into one category, with a full range of dispositional options available in all cases.

The dominant parental fault model frames debates over child abuse and neglect definitions and dispositions as conflicts between narrowing the definition to “preserve parental rights and family privacy” and broadening it to “maximize state interventions to protect at-risk children.”²⁶⁶ A public health approach would address these issues differently, by asking what standards can help focus coercive governmental responses where they are most effective and necessary and leave space for less invasive and more effective interventions in other cases. The problem with broad definitions is not only that they permit too many invasions of family integrity, but that they also lead state authorities to direct their attention to too many cases, causing more serious cases to slip through the cracks.²⁶⁷

A public health approach would also seek to identify widely accepted definitions of child abuse and neglect as a tool to develop statistically valid data regarding child maltreatment and thus make the most informed policy choices. The absence of reasonably consistent practice denies researchers and policy-makers a shared understanding of what child abuse and neglect is; indeed, society likely lacks a shared understanding of what parental conduct is so bad that it should be outlawed. Yet such a baseline is essential to developing key

(requiring the court to find that the child has been abused or neglected “and that retention of the child in or return of the child to the home would place the child at unreasonable risk of harm . . . and the child cannot reasonably be protected from this harm without being removed”).

264. *E.g.*, D.C. CODE § 16-2319 (2001) (directing the child welfare agency to file a detailed disposition report to the court after it has adjudicated a petition).
265. First, federal law exempts child welfare agencies from requirements to work to reunify families when “aggravated circumstances” exist, such as murder or voluntary manslaughter of another child. 42 U.S.C. § 671(a)(15)(D)(2006). Second, a small number of states create tiers for their child abuse and neglect registries. *See supra* note 249 and accompanying text.
266. Hafemeister, *supra* note 49, at 845.
267. Richard Gelles, for instance, has called for narrowed definitions of abuse or neglect so that state authorities can better focus their activities. GELLES, *supra* note 181, at 155–57. *See also supra* note 81 and accompanying text (finding more effective sexual abuse investigations when investigators focused on a narrower range of cases).

epidemiological tools; it is impossible to create valid actuarial models that predict risk of future abuse or neglect, for instance, without a clear understanding of what constitutes abuse or neglect.²⁶⁸ This is a particularly large problem in child protection, in which existing law has led to absurdly large variations in the number of children deemed abused or neglected by different states' child protection agencies. At the low end, Pennsylvania authorities deemed only 1.2 per 1000 children in that state to have been abused or neglected, while at the high end, New York authorities deemed 16.9 per 1000 children to have been abused or neglected.²⁶⁹ New York parents are not fourteen times more abusive and neglectful than Pennsylvania parents; rather, the statistics reflect different understandings of "abuse" and "neglect" in different state agencies.²⁷⁰ Absent a uniform or standardized understanding of what constitutes abuse or neglect, applied relatively consistently across jurisdictions,²⁷¹ authorities develop risk assessments tied to the likelihood of CPS involvement in that particular state.²⁷² Resulting assessments are thus designed to reproduce existing practice rather than to predict more accurately the risks that a child will face. To shape improved practice would require clearer definitions of abuse or neglect, which would provide clearer norms for the next generation of risk assessments. The problem is severe enough that the Centers for Disease Control felt it necessary to propose uniform definitions of abuse and neglect in 2008 so that public health practitioners could measure child abuse and neglect more accurately and identify those groups who could most benefit from targeted interventions.²⁷³

States²⁷⁴ should define abuse and neglect more narrowly. Narrower definitions should limit court cases and their inherent coercion to those that are more serious, in which a child has suffered or faces

268. See Marsha Garrison, *Taking the Risks out of Child Protection Risk Analysis*, 21 J.L. & POL'Y 5, 25 (2012) (criticizing child protection risk assessments for failing to use "standardized definitions of abuse and neglect").

269. CHILD MALTREATMENT 2011, *supra* note 45, at 32. This Article excludes the District of Columbia's even higher ratio—22.6 per 1000—because the unique boundaries of that city-"state" make for difficult comparisons.

270. No correlation exists between states' risk factors for child maltreatment and the rates at which state child protection authorities find child maltreatment to exist. Wald, *supra* note 78.

271. Many variables besides the legal definitions themselves can affect different practices, including high-profile child fatalities and changes in agency leadership. Because this Article focuses on a public health legal structure, this Article focuses on the legal definitions.

272. Garrison, *supra* note 268, at 27.

273. CHILD MALTREATMENT SURVEILLANCE: UNIFORM DEFINITIONS FOR PUBLIC HEALTH AND RECOMMENDED DATA ELEMENTS 3, CENTERS FOR DISEASE CONTROL & PREVENTION (2008), http://www.cdc.gov/violenceprevention/pdf/cm_surveillance-a.pdf.

274. This Article uses the word "states" because Congress has declined to establish federal definitions of child abuse and neglect through federal funding statutes.

too great of a risk of suffering a serious physical injury, a serious emotional harm, or some other significant obstacle to proper development caused by blameworthy parental conduct. With more precise definitions, researchers should study which dispositions are most effective for which cases, and the law—through legislation, agency regulation, and case law—should direct appropriate dispositions accordingly.

V. LEGAL REFORMS TO PROVIDE FAMILIES SERVICES REGARDLESS OF CPF FINDING PARENTAL FAULT

A public health approach would limit the use of coercive legal intervention. Investigating a family and labeling a parent “unfit,” with all the harms and stigma that entails, should be reserved for severe cases or when less coercive steps have failed. When children or parents need services, and seek out or would voluntarily participate in such services, then the law should not require the use of a CPS middleman, which would delay the provision of services and unnecessarily investigate and potentially label the family.²⁷⁵ There is especially no need for the state to take custody of a child as a means of providing services. Legal reforms are necessary to put these public health principles into practice.

An extreme example involves the use of foster care not to protect children from unfit parents but to qualify children for mental health services. Thousands of cases involve children who are placed in foster care in order to qualify them for mental health services that parents cannot obtain on their own.²⁷⁶ Some states define neglect to include situations when a child needs mental health care “and the parent . . . is unable to afford or access appropriate mental health treatment or care for the child.”²⁷⁷ These cases represent an extreme failure to follow a public health approach: the state weakens children’s

E.g., 42 U.S.C. § 5106a(b)(2)(B)(ii)(I) (Supp. V 2011) (disclaiming any federal definition of abuse or neglect).

275. *Supra* notes 200–01 and accompanying text.

276. Weithorn, *supra* note 112, at 1375–76.

277. MO. REV. STAT. § 211.031.1(1)(d) (West 2010). *See also, e.g., In re W.L.H.*, 739 S.E.2d 322, 326 (Ga. 2013) (Hunstein, C.J., dissenting) (reciting the trial court’s finding “that the child was deprived on the ground that his guardians’ lack of financial resources made them incapable of securing the residential treatment he needed”). The Bazelon Center for Mental Health Law has asserted that “at least half of the states” force parents to “choose between getting the mental health treatment their child needs and retaining legal custody of the child” and estimates the number of affected families in the thousands. Mary Giliberti & Rhoda Schulzinger, *Relinquishing Custody: The Tragic Result of Failure to Meet Children’s Mental Health Needs Executive Summary*, THE BAZELON CENTER FOR MENTAL HEALTH LAW 1 (2000), <http://www.bazelon.org/LinkClick.aspx?fileticket=-hWbIbUX5v8%3d&tabid=104>. For a parent’s first-hand account of one such case, see TONI HOY, *SECOND TIME FOSTER CHILD: ONE FAMILY’S FIGHT FOR THEIR SON’S MENTAL HEALTHCARE AND PRESERVATION OF THEIR FAMILY* (2012).

legal bonds with their parents when a parent has done nothing wrong and when the coercive legal step is unnecessary for their protection. These states place foster care on the table only because of the state's failure to offer a continuum of services that all parents can afford. Neglect definitions should be reformed to preclude using foster care to remedy that failure.

Law reform must focus on building a children's mental health system that can provide adequate services without families ever turning to foster care to obtain voluntary mental health services.²⁷⁸ Medicaid and other health care funding streams may provide some paths to ensuring adequate funding for effective interventions at all stages of a continuum, something that is essential to providing adequate funding to meeting the full range of needs.²⁷⁹ If families could obtain necessary mental health care for children without surrendering custody of their children, then there would be little use of foster care as a means of obtaining mental health care.

More broadly, the present child welfare system too often conditions services to families on CPS agencies completing investigations and substantiating abuse or neglect. A parental-fault paradigm supports such a condition because that paradigm seeks to know whether a parent has committed a bad act before determining how to respond. But it is not justified on empirical data about risk to children, which shows that substantiating one allegation of maltreatment bears little statistical relationship to future risk to the child.²⁸⁰ For the millions of families of children at high risk for poor life outcomes, the law should separate the provision of services from some finding of parental fault.²⁸¹ Unfortunately, that is not the reality; CPS agencies are more than twice as likely to provide services to families following substantiated investigations, and some states even refuse to offer services unless they substantiate an allegation of abuse or neglect.²⁸² To reform the practice, states should, whenever possible, separate the provision of services from an investigation. This goal is best accomplished through differential response programs, discussed in section II.B

278. The problems include the school system, public and private health insurers, and the general shortage of community mental health services. Weithorn, *supra* note 112, at 1376.

279. WULCZYN ET AL., *supra* note 113, at 185. Mental health advocates have explained how major federal funding streams like Medicaid can help ensure access to mental health services without using foster care. *Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment*, THE BAZELON CENTER FOR MENTAL HEALTH LAW (2002), <http://www.bazelon.org/LinkClick.aspx?fileticket=-g7QVr0wWF8%3d&tabid=104>.

280. Kohl et al., *supra* note 122.

281. *See id.* at 23 ("Services decisions should be decoupled from the idea of substantiation.")

282. Kohl et al., *supra* note 122, at 18.

above; among other benefits, differential response leads to faster provision of services, in part because families do not have to wait for CPS to complete an investigation.²⁸³ It is particularly well-accomplished through innovations like the Parent Support Outreach Program—programs which operate separately from CPS agencies and to which other professionals may refer families in place of a CPS referral.²⁸⁴ For cases that remain assigned to CPS agencies for investigation, the law should require CPS agencies to offer services to families regardless of whether the agencies substantiate maltreatment allegations and to assess service needs and provide services during the course of an investigation unless doing so would jeopardize the investigation.

The federal Child Abuse Prevention and Treatment Act codifies one element of this practice, requiring child welfare agencies to refer any child under three “who is involved in a *substantiated* case of child abuse or neglect”²⁸⁵ to early childhood special education programs. Under this law, to trigger the referral, one would need a CPS report, an investigation, and substantiation. Children are thus excluded from this referral mandate if they are (a) not reported, (b) placed on a differential response track, or (c) subject to allegations that are investigated but not substantiated. From a public health perspective, a young child who is the subject of a child abuse and neglect referral is likely to benefit from a developmental screening and any necessary services—and thus a referral to early childhood special education. There is no principled reason to limit such referrals to substantiated cases. The law should require CPS agencies and other public agencies in contact with young children to make such early intervention referrals directly without conditioning them on substantiation.

VI. REFORMING FEDERAL CHILD WELFARE FUNDING TO SUPPORT A PUBLIC HEALTH APPROACH

Although funding streams shape the institutions that provide interventions to increase health, public health “researchers have not properly studied funding laws.”²⁸⁶ This section focuses on federal funding streams because foster care services and most services provided to families to prevent maltreatment receive a significant amount of funding from the federal government.²⁸⁷ Moreover, federal

283. See *supra* note 225 and accompanying text.

284. See *supra* notes 234–42 and accompanying text.

285. 42 U.S.C. § 5106a(b)(2)(B)(xxi) (Supp. V 2011) (emphasis added).

286. Susan Vivian Mangold et al., *Using Community-Based Participatory Research to Study the Relationship Between Sources and Types of Funding and Mental Health Outcomes for Children Served by the Child Welfare System in Ohio*, 21 J.L. & POL'Y 113, 125 (2012).

287. State and local funding streams can also shape outcomes. Susan Mangold and Catherine Cerulli found a correlation between a dedicated child welfare property tax levy in some Ohio counties and higher adoption rates and lower foster care

funding is so significant that it shapes state and local child welfare policies—and plays an “often determinative” role in such policies.²⁸⁸ Federal child welfare funding is particularly complicated because many states use multiple federal funding streams to support state and local child welfare agencies²⁸⁹ and because states vary in the proportion of federal, state, and local funds used for child welfare agencies.²⁹⁰ This section will focus on Title IV-E of the Social Security Act, which governs federal funding for state agencies serving children in foster care.

A central element of a public health approach is that society should make available a spectrum of interventions and choose the most effective intervention for a particular family.²⁹¹ Federal funding schemes should support all elements along that spectrum equally and should not create financial incentives to choose one option along that spectrum. Individual decisions of which interventions to choose should depend on their likely effectiveness, and policy decisions regarding which interventions to invest in—and thus make available for individual cases—should depend on their effectiveness and the need of the population. Neither set of decisions should depend on funding availability. Moreover, if a public health approach endorses particularly invasive alternatives only when necessary,²⁹² then any differential in federal funding should disfavor the most invasive interventions.

Present federal funding works in the opposite manner: state child welfare agencies receive Title IV-E funds as entitlement payments for all eligible foster children. Federal law places no cap on either the number of children for whom state agencies can claim Title IV-E funds or the amount of funds states can claim for particular children—at least for children whom state agencies have removed from their homes and placed in foster care. Conversely, funds for services to prevent the need for foster care through Title IV-B of the Social Security Act are fixed and about ten times lower than the total amount of Title IV-E

populations. Susan Vivian Mangold & Catherine Cerulli, *Follow the Money: Federal, State, and Local Funding Strategies for Child Welfare Services and the Impact of Local Levies on Adoptions in Ohio*, 38 CAP. U. L. REV. 349, 374-82 (2009); see also Mangold et al., *supra* note 286, at 125 (finding “a positive correlation between flexible local funding and outcomes that lead to improved mental health for children in foster care”).

288. Mangold & Cerulli, *supra* note 287, at 351; see also Vivek Sankaran, *Innovation Held Hostage: Has Federal Intervention Stifled Efforts to Reform the Child Welfare System?*, 41 U. MICH. J.L. REFORM 281, 287 (2007-2008) (describing child welfare policy as “driven by federal law”).

289. In addition to Title IV-E funds discussed above, states can use Social Security Block Grants and Temporary Assistance to Needy Families block grant funds to support child welfare activities.

290. Mangold & Cerulli, *supra* note 287, at 352-53.

291. See *supra* notes 156-62 and accompanying text.

292. See *supra* note 144 and accompanying text.

funds provided.²⁹³ Moreover, when budget cuts from the so-called “sequester” took effect in 2013, Title IV-E foster care payments were exempted from cuts while prevention services faced cuts.²⁹⁴ States replicated this budget-cutting pattern as they cut their budgets during the great recession and its aftermath, and they focused cuts on child-abuse and neglect prevention programs rather than the foster care programs that receive more federal funding and have more federal mandates.²⁹⁵

Federal incentive payments are available to states that increase the number of children adopted into new families out of foster care,²⁹⁶ but no such incentives exist for keeping children safely at home. A state agency will thus receive relatively little federal financial support to work to keep a child with his family, but it will receive federal reimbursement of 50–83% of all eligible costs if it removes that child from his family.²⁹⁷ This funding structure may contribute to disparity in specialized services. Although children in and out of foster care need such services, those in foster care, for whom CPS agencies may claim federal support, are more likely to receive specialized services.²⁹⁸ At the very least, the absence of significant sustained funding for prevention services creates a “very challenging context for mounting a program of evidence-based parent-mediated interventions.”²⁹⁹

This harm is compounded by a further quirk of federal funding law: to obtain federal funding for foster care services to a particular child, a child welfare agency must document not only that the child was abused or maltreated, but also that the child is poor enough to

293. Sankaran, *supra* note 288, at 300; Mangold & Cerulli, *supra* note 287, at 363, 370.

294. Lisa Pilnik, *Advocates See Impacts from Sequester, Brace for More*, YOUTH TODAY (Apr. 26, 2013), http://www.youthtoday.org/view_article.cfm?article_id=6002.

295. Illinois illustrates the point: a \$50 million reduction in the Department of Children and Family Services was focused on prevention programs, and more than 275 of 375 layoffs were of staff who worked with families to avoid the need for foster care. Bill Ruthhart, *DCFS Cuts May Force More Kids into Foster Care: Intact Family Services Slashed as Agency Lays off Staff, Tightens Eligibility Rules*, CHI. TRIB. (Sept. 4, 2012), http://articles.chicagotribune.com/2012-09-04/news/ct-met-dcfs-intact-families-20120904_1_dcfs-cuts-dcfs-investigator-dcfs-director-richard-calica; Doug Finke, *Department of Children and Family Services Mulls Cuts, Layoffs*, ST. J.-REG. (June 20, 2012), <http://www.sj-r.com/top-stories/x1884284408/Illinois-DCFS-mulls-cuts-layoffs>.

296. 42 U.S.C. § 673b (2006).

297. See 42 U.S.C. §§ 674(a)(1) (2006) (setting the federal reimbursement rate for “foster care maintenance” costs as the same as the federal Medicaid reimbursement rate); § 1396d(b) (Supp. V 2011) (setting a minimum and maximum Medicaid reimbursement rate of 50% and 83%, respectively). A state agency that reunifies a foster child with her family will lose its Title IV-E funding for that child’s case and rely more significantly on its own funding for services and case management for the reunified child. Sankaran, *supra* note 288, at 300–01.

298. WULCZYN et al., *supra* note 113, at 86.

299. WULCZYN et al., *supra* note 113, at 163.

have been eligible for Aid to Families with Dependent Children.³⁰⁰ Tying eligibility to that program is at best anachronistic (it was transformed to Temporary Aid to Needy Families in the 1996 welfare reform) and at worst imposes administrative burdens on child welfare agencies and focuses case workers on families' poverty rather than their needs.³⁰¹ Most importantly for this Article's argument, it illustrates the lack of coherent rationale behind the present funding regime and thus the value of reform.

The federal government should expand and make permanent the ability of states to seek waivers from requirements regarding how federal child welfare funds are spent; that authority is currently subject to an expiration date and a limit on the number of states that can obtain a waiver.³⁰² Such waivers provide states an annual lump sum of federal funding;³⁰³ in exchange for foregoing Title IV-E's uncapped entitlement to federal funding if the number of foster children increases, states receive the flexibility to use federal funding as they see fit—including reducing the number of children removed. Indeed, past federal waivers have shown states that sought to do so invested in services designed to prevent the need for foster care³⁰⁴—thus creating a broader spectrum of services, consistent with a public health approach. Similarly, most states receiving the current federal waivers appear to be using the flexibility granted to them to invest in prevention services.³⁰⁵ Moreover, developing such services led to greater collaboration with other government agencies and community-based

300. 42 U.S.C. § 672(a)(3)(2006).

301. Susan Vivian Mangold, *Poor Enough to be Eligible? Child Abuse, Neglect, and the Poverty Requirement*, 81 ST. JOHN'S L. REV. 575 (2007).

302. The statute currently grants the U.S. Department of Health and Human Services authority to issue waivers from Title IV-E requirements to up to ten states. 42 U.S.C. § 1320a-9(a)(2) (Supp. V 2011). Not only are the number of waivers limited, but the authority to grant them is time-limited, expiring in 2014, *id.*, and Congress has previously granted waiver authority only to let it expire. INFORMATION MEMORANDUM: CHILD WELFARE DEMONSTRATION PROJECTS FOR FISCAL YEARS 2012-2014, ACYF-CB-IM-12-05, at 2-3, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. ON CHILD., YOUTH & FAMILIES (2012), available at <http://www.acf.hhs.gov/sites/default/files/cb/im1205.pdf>.

303. SYNTHESIS OF FINDINGS: TITLE IV-E FLEXIBLE FUNDING: CHILD WELFARE WAIVER DEMONSTRATIONS, 5, U.S. DEP'T OF HEALTH & HUMAN SERVICES, ADMIN. FOR CHILD. & FAMILIES, ADMIN. ON CHILD., YOUTH & FAMILIES (2011), available at <http://www.acf.hhs.gov/sites/default/files/cb/flexible.pdf>.

304. *Id.* at ii-iii, 14.

305. JooYeun Chang, *Innovation in Child Welfare Continues with 8 New Title IV-E Waiver Demonstrations*, FAM. ROOM BLOG (Sept. 30, 2013), <http://www.acf.hhs.gov/blog/2013/09/innovation-in-child-welfare-continues-with-8-new-title-iv-e-waiver> (reporting that five of the eight states receiving waivers in 2013 are increasing investments in services designed to prevent the need for foster care).

organizations,³⁰⁶ entities that might be more inclined to see options other than removing children.

Data from past “flexible funding” waivers is inconclusive but suggests that states that use flexible funding to increase the availability of services can reduce the number of children removed from their families while simultaneously improving child safety outcomes as measured by repeat instances of child maltreatment. Florida achieved the most dramatic results, reducing its foster care population by 38% over four years while reducing the number of children who experienced maltreatment within six months of the child welfare agency closing their cases from 8.2% to 5.2%.³⁰⁷ Of the four states that used flexible funding to prevent the need for foster care placements (Florida, Indiana, North Carolina, and Ohio), three were able to do so to a statistically significant degree (Florida, Indiana, and Ohio). And two of these states (Florida and Indiana) also succeeded in reducing the incidence of repeat maltreatment, while the third (Ohio) saw no impact in that incidence—suggesting that keeping children out of foster care is not associated with increased safety risks to children.³⁰⁸

VII. BUILDING INSTITUTIONAL CAPACITY BEYOND CPS TO APPLY A PUBLIC HEALTH APPROACH IN COMMON FACT PATTERNS

The above reforms alone are necessary but not sufficient to develop a public health approach. An essential problem is that institutions and individuals best suited to lead a public health response to child maltreatment are not presently structured to do so, lack the legal tools and mandates to do so,³⁰⁹ and have few options other than calling child protection authorities to address concerning situations.³¹⁰ The solution then is to pursue legal reforms that will build institutions’ and individuals’ ability to implement a public health approach.

This task is immensely complicated because of the wide range of institutions that are poised to catalyze a public health response. Those entities include community health centers, pediatricians’ offices, and any number of public and private social service agencies whose clientele include children or parents, especially those with risk factors for child maltreatment. These reforms will necessarily vary from institution to institution and will depend on the unique body of

306. *Id.* at 21.

307. *Id.* at 28–30.

308. *Id.* at iii, 27.

309. Lois Weithorn also argues adoption of “positive mandates” to provide effective interventions before we impose negative mandates—prohibitions on certain invasive actions—on institutions. Weithorn, *supra* note 112, at 1475–76.

310. Gilbert et al., *supra* note 48, at 334 (describing the limited options pediatricians have for referring families for assistance).

laws that govern different types of institutions—and so a full catalog of reforms is beyond this Article’s scope. This section will focus on two areas to illustrate legal reforms that can help build a public health approach: the roles of public schools—early childhood programs, elementary schools, and secondary schools—encountering children who may have been abused or neglected and the roles of hospitals and medical personnel encountering pregnant and postpartum women who abuse substances.

A. Building a School-to-Health Pipeline

This Article uses schools as an example for several reasons. First, school personnel consistently account for the largest single source of child maltreatment reports of any group—about 17% of all reports.³¹¹ Second, schools are among those best suited to arrange a public health response because they are familiar with children in their full context, including their families, peer groups, and communities.³¹² Schools see school-age children more than any other institution beyond the family. Children are compelled to attend school,³¹³ and the age at which children may begin to attend school is gradually dropping with the expansion of public pre-kindergarten programs.³¹⁴ School days account for about half of school-aged children’s lives.³¹⁵ Schools also see these children’s families at school drop-off and pick-up, for younger children at least, and when students have problems at school. Third, schools should have an incentive to understand the various possible causes of children’s behavioral struggles because behavioral problems stemming from child maltreatment are important contributors to academic failure.³¹⁶ Fourth, schools have historically been and

311. Following the federal government’s categories, “education personnel” and “child daycare providers” accounted for 17.8%, 17.6%, 17.2%, 17.3%, and 16.7% of all child maltreatment reports each year, respectively, from 2007 through 2011. They were followed by legal and law enforcement personnel (about 16% each year) and social services personnel (10–11% each year)—although some of these reporters may work at schools, such as school police officers or school social workers. CHILD MALTREATMENT 2011, *supra* note 45, at 8.

312. *Cf. Todres, supra* note 144, at 494 (“[T]eachers and other school officials often are well positioned to identify vulnerable children before they are exploited.”)

313. *E.g.*, MO. REV. STAT. § 167.031(1).

314. For instance, the District of Columbia has dramatically expanded access to free public preschool programs for three- and four-year-olds. Pre-K Enhancement and Expansion Act of 2008, D.C. CODE tit. III, § 38-272.05 (2008), *available at* <http://dcclims1.dccouncil.us/images/00001/20080515162055.pdf>.

315. States set the length of school years, most commonly 180 days and no less than 160 out of 365. EDUC. COMM’N OF THE STATES, STATE NOTES: SCHEDULING/LENGTH OF SCHOOL YEAR (2008), *available at* <http://www.ecs.org/clearinghouse/78/24/7824.pdf>.

316. *See, e.g.*, Nancy Buchanan, *The Effects of Parental Involvement on 12th Grade Achievement*, 4 GEO. PUB. POL’Y REV. 75, 75 (1998) (“It is widely accepted that both family behaviors and characteristics play a critical role in the academic

continue to be a locus of public health efforts—immunization requirements, vision and hearing tests, health classes³¹⁷—and can similarly become essential agents in a public health approach to child welfare.

Despite these factors, schools generally do not consider a public health approach to the child maltreatment they frequently observe. Faced with a child experiencing some form of maltreatment and the behavioral and academic consequences of it, schools typically focus on a limited range of services for children, impose punishments on children when maltreatment leads to bad behavior, or call a child protection hotline to report possible maltreatment. The present child welfare system's suggestion to schools addressing such situations is predictable—train school staff to identify and report suspected maltreatment.³¹⁸ While such hotline calls will often be appropriate, a legal structure in which other actions are encouraged would represent a large amount of progress.

Returning to the hypothetical from Part II, the social worker should have several options besides calling the child protection hotline and commonly available school interventions, such as disciplining the student, assigning the student a tutor, or referring the student for special education. To name some steps, the social worker could refer the child's mother—who she thought exhibited signs of clinical depression—to mental health providers.³¹⁹ She could refer the family to specific programs proven to help parents address the difficult behaviors.³²⁰ She could ask the mother what she needed to help stabi-

growth and achievement of children . . ."); BARBARA T. KELLEY ET AL., U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, IN THE WAKE OF CHILDHOOD MAL-TREATMENT 1 (1997), available at <http://www.ncjrs.gov/pdffiles1/165257.pdf> (explaining that children who experience maltreatment are more likely to have low academic achievement and various other negative social outcomes).

317. James G. Hodge Jr. & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, 90 Ky. L.J. 831 (2002).
318. The federal government's guide to educators regarding child maltreatment emphasizes identification and reporting of maltreatment. THE ROLE OF EDUCATORS IN PREVENTING AND RESPONDING TO CHILD ABUSE AND NEGLECT 8, U.S. DEP'T OF HEALTH & HUMAN SERVICES, ADMIN. FOR CHILD. & FAMILIES (2003), available at <https://www.childwelfare.gov/pubs/usermanuals/educator/educator.pdf>. It also addresses "preventing child abuse and neglect," *id.*, but the suggestions involving prevention are all focused on services directed at children, not any directed at parents or families, thus failing to address children in their context. *Id.* at 45–53.
319. Maternal depression is a common and treatable condition often cited as a risk factor for child maltreatment. TRACY VERICKER ET AL., INFANTS OF DEPRESSED MOTHERS LIVING IN POVERTY: OPPORTUNITIES TO IDENTIFY AND SERVE 1 (2010), available at <http://www.urban.org/UploadedPDF/412199-infants-of-depressed.pdf> (linking maternal depression to poor parenting and physical and mental health problems in children).
320. Various mental health programs have been proven to help parents manage difficult behaviors of children of various ages. See WULCZYN ET AL., *supra* note 113, at 156 (listing evidence-based interventions). Multi-Systemic Therapy ("MST") addresses multiple causes of troublesome adolescent behavior, including parental

lize her home. Perhaps some public benefits were cut off, perhaps the mother is facing eviction, or perhaps she needs legal assistance protecting herself or her children from an abusive partner.³²¹ The social worker could refer her to public benefits programs or, if needed, to an employment access.

Several concerns about our present legal structure are apparent in these answers. First, the law does not currently require schools to take steps that focus on the needs of families; interventions generally focus on the child. As a result, any school social worker who takes these steps will likely be an outlier. Second, the school social worker may not have the most effective referral sources or know which programs will be willing to serve this family at low or no cost or, perhaps, which programs would be compensated through public sources (such as Medicaid). Third, it will be difficult for the school social worker to follow up with the mother or coordinate different services. It is likely beyond the social worker's authority to ask for information regarding the mother's progress absent the mother's consent.

These concerns help outline legal reforms that can help schools initiate a public health response. First and foremost, when schools reasonably suspect a child is at risk of maltreatment, the law should charge schools with helping students and their families obtain services to prevent maltreatment and thus empower students to succeed academically. Such a charge should not be overly prescriptive, as schools and school districts need time and flexibility to identify the best way to meet this charge. The charge could come through state or local statutes or regulations; contracts or policies defining school so-

problems. Weithorn, *supra* note 112, at 1494–95. Parent Management Training has been proven effective at reducing symptoms of children's conduct disorder. ALAN E. KAZDIN, PARENT MANAGEMENT TRAINING: TREATMENT FOR OPPOSITIONAL, AGGRESSIVE, AND ANTISOCIAL BEHAVIOR IN CHILDREN AND ADOLESCENTS (2005); J.D. Cautilli & T.C. Tillman, *Evidence Based Practice in the Home and School to Help Educate the Socially Maladjusted Child*, 1 J. EARLY & INTENSIVE BEHAVIOR INTERVENTION 27 (2004). Parent-Child Interaction Therapy has been proven effective in reducing physical abuse, especially of young children. M. Chaffin et al., *Parent-Child Interaction Therapy with Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports*, 72 J. CONSULTING & CLINICAL PSYCH. 500 (2004).

321. One law school clinic helped establish a legal services center for families at risk of foster care, and the clinic achieved promising results. DETROIT CENTER FOR FAMILY ADVOCACY PILOT EVALUATION REPORT 7/2009–6/2012 (2013), available at <http://xa.yimg.com/kq/groups/3808685/1466853936/name/Final%20Evaluation.pdf> (2013). If such results can be established with an experimental design and replicated, then broadly applying such legal services models would be an essential piece of a public health approach. A community schools program in Syracuse, New York, has also included a legal services component for families of public school students. Say Yes to Educ. Syracuse, *Free Legal Clinics*, <http://www.sayyessyracuse.org/family-resources/free-legal-clinics> (last visited Aug. 21, 2013); Sarah D. Sparks, *Syracuse 'Says Yes' to Whole Child*, EDUC. WEEK, Aug. 7, 2013, at 24–25.

cial workers' jobs as identifying services for students and their families outside of schools; state or federal (or even private) grant programs; or some other source. Schools can begin to address that charge by offering school-based mental health programs proven to have some benefit for youth and their families.³²² Schools could devote staff to coordinate services inside and outside of school³²³ or expand "community schools" programs that link schools with local mental health providers to establish school-based clinics that provide counseling and crisis interventions to students and their families.³²⁴ Such efforts appear to have some success—reducing drop-out and school-suspension rates while improving academic achievement, school attendance, and high school graduation rates and claiming success in reducing abuse and neglect within families.³²⁵

That charge can be facilitated through schools and local service providers sharing information—with the parent's consent—about developments in and out of school so comprehensive services can be provided; where some large urban areas have developed the technological infrastructure to share information regarding a family in the context of CPS investigations, they could instead focus on creating the infrastructure to easily share information—again, with parents' consent—between the various entities working with a family.³²⁶ Staff—both

322. See Weithorn, *supra* note 112, at 1360 (collecting studies).

323. See Coleman, *supra* note 203, at 156, 157 (describing North Carolina schools' "child and family support teams," which coordinate services for children, a mandate which could be expanded to include services for parents in some cases).

324. Scott Bloom, *Mental Health Services, in COMMUNITY SCHOOLS IN ACTION: LESSONS FROM A DECADE OF PRACTICE* 98–113 (Joy G. Dryfoos et al. eds., 2005). Partnering with community organizations can help prevent overburdening teachers with new duties—a point community schools' advocates appear to recognize. See, e.g., *COMMUNITY SCHOOLS IN ACTION: LESSONS FROM A DECADE OF PRACTICE* 187 (Joy G. Dryfoos et al. eds., 2005) ("Partners such as CAS [Children's Aid Society] come into the building and take responsibility for health, social services, extended hours, and parent and community involvement.").

325. ICF INTERNATIONAL, *COMMUNITIES IN SCHOOLS NATIONAL EVALUATION: FIVE YEAR SUMMARY REPORT* 7–10 (2010), available at <http://www.communitiesinschools.org/about/publications/publication/five-year-national-evaluation-summary-report>; MARTIN J. BLANK ET AL., *MAKING THE DIFFERENCE: RESEARCH AND PRACTICE IN COMMUNITY SCHOOLS* 40–43 (2003), available at <http://www.communityschools.org/assets/1/Page/CCSFullReport.pdf>. One similar program displays a sharply declining foster care population as a "result" of its work. See Say Yes to Educ. Syracuse, *Results: Community Engagement*, <http://www.sayyessyracuse.org/results> (listing 45% decline in county foster care population since 2005 as a program "result"). Proving that the program was a cause of this decline requires more rigorous study. But the claim of such causation has intuitive appeal—providing a range of voluntary services to children and families early should prevent some maltreatment.

326. California law permits such information sharing when a CPS hotline call is made. CAL. WELF. & INST. CODE § 18961.5 (1992). Los Angeles County has taken steps to implement it. COUNTY OF LOS ANGELES, CHIEF EXECUTIVE OFFICE, *INFORMATION SHARING TO PREVENT CHILD ABUSE AND UTILIZATION OF THE COUNTY'S*

the school social workers and staff of other service providers—should be trained to work effectively across the mental health and educational systems and other systems with which students and their families frequently interact.³²⁷

Even with such a charge, school social workers will not be able to accomplish all goals that they set for a child directly. It is important in these cases to create options other than calling CPS, such as referrals to the voluntary services program piloted in Minnesota.³²⁸ Relatedly, states could create public health hotlines, in which school officials (and other professionals who are currently mandatory reporters) could call service providers better equipped to provide the necessary assistance, and do so without stigmatizing the family,³²⁹ or to which families could self-refer with less fear that asking for help would lead to CPS taking their children.³³⁰ Or, as Lois Weithorn has suggested, states could create “triage centers,” which could evaluate a family and arrange for appropriate services provided by various agencies,³³¹ and school social workers could refer families to such centers for assessment. Or, as one state adopted as school reform, states could establish “Family Resource and Youth Service Centers” from which families could seek assistance or to which schools could refer families.³³² If, as recommended in Part V, federal child welfare funding permitted more flexibility, states could use some of these funds to help establish the services in question.

B. Maternity Wards, Physicians, and Prenatal Drug Exposure

By any measure, substance abuse during pregnancy, including both illegal and legal drugs, especially alcohol, is a huge public health problem. It significantly increases infant mortality; one study found

FAMILY AND CHILDREN'S INDEX (2009), available at http://file.lacounty.gov/bc/q2_2009/cms1_133889.pdf.

327. Weithorn, *supra* note 112, at 1484–87. Professional organizations have developed guides to navigate confidentiality laws. *E.g.*, KATHLEEN McNAUGHT, MYTHBUSTING, *Breaking Down Confidentiality and Decision-Making Barriers to Meet the Education Needs of Children in Foster Care* (2005), available at http://www.svcf.org/media/articles/files/Mythbusting_Information_Sharing.pdf.
328. *Supra* notes 235–42 and accompanying text.
329. Coleman, *supra* note 203, at 167 (describing interventions by health officials as less stigmatizing and intrusive than those by CPS officials).
330. If, as suggested *supra* in notes 231–32 and accompanying text, differential response systems could be administered by entities separate from child protection agencies, then those entities could both reduce the coercion inherent in a CPS agency response and provide appropriate referrals for families.
331. Weithorn, *supra* note 112, at 1481–83.
332. S. REG'L EDUC. BD., HELPING FAMILIES TO HELP STUDENTS: KENTUCKY'S FAMILY RESOURCE AND YOUTH SERVICES CENTERS (2001), available at http://publications.sreb.org/2001/01H01_Helping_Families.pdf.

that mothers in substance-abuse treatment reported an infant mortality rate for prior children more than double that of the general population.³³³ Alcohol abuse during pregnancy is the leading cause of intellectual disabilities and a leading cause of neurological disorders.³³⁴ It causes hundreds of millions of dollars in medical costs for illegal drug-exposed infants and billions of dollars in costs related to fetal alcohol syndrome.³³⁵

Substance-exposed newborns are often referred to child protection authorities, although the exact number of referrals and how CPS agencies handle them are hard to pin down precisely.³³⁶ Historically, concern about drug-exposed newborns was a key factor in the sharp increase in the number of foster children in the 1980s and 1990s,³³⁷ and federal funding statutes now require states to make hospitals report drug-exposed infants to child protection authorities as part of mandatory reporting statutes.³³⁸

Treating substance abuse by pregnant women as a per se cause for coercive child protection intervention is problematic. Research shows that the most effective way to help drug-addicted mothers of young children recover is to keep them together and especially to permit such mothers to bring their children into inpatient drug treatment. In one study, 48% of women who had infants living with them completed

333. H. Westley Clark, *Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children: Treatment and Policy Implications*, 80 *CHILD WELFARE* 179, 187 (2001).

334. ACOG OPINION 422, *supra* note 197, at 1.

335. *Id.*

336. SUBSTANCE-EXPOSED INFANTS: STATE RESPONSES TO THE PROBLEM 37, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. (2009) [hereinafter SUBSTANCE-EXPOSED INFANTS]. This failure to collect basic data and track the effectiveness of existing interventions is itself a failure to apply basic lessons of the public health field. Garrison, *supra* note 129. One of the few states that did track CPS reports regarding substance-exposed infants found only five out of 1000 births led to such reports. Mark F. Testa & Brenda Smith, *Prevention and Drug Treatment*, 19 *THE FUTURE OF CHILDREN* 147, 152 (2009). Extrapolated across the nation, in which there are about 4.2 million births annually, <http://www.cdc.gov/nchs/fastats/births.htm>, suggests about 20,000 such reports each year. That does not include reports regarding infants whose parents are suspected of a substance-abuse problem that is not discovered until later. James Dwyer has also concluded that hospital staffs report only a small portion of substance-exposed infants to child protection authorities. Dwyer, *supra* note 198, at 445, 448.

337. Removals of children born to substance-abusing mothers formed a hugely disproportionate amount of the increasing foster care population in those years; removals of infants increased 89% in New York and 58% in Illinois over three years, and most of those removals occurred "within days following birth." Eugene M. Lewit, *Children in Foster Care*, 3 *FUTURE OF CHILDREN* 192, 196-98 (1993), available at http://www.princeton.edu/futureofchildren/publications/docs/03_03_Indicators.pdf.

338. 42 U.S.C. § 5106a(b)(2)(B)(ii) (2006).

treatment, compared to 17% of women who did not have their children with them.³³⁹ Limited availability of services should not force mothers to choose between entering treatment and maintaining custody of their children. Moreover, the risks to children from prenatal drug exposure are often overstated. Prenatal drug exposure can increase the risk of premature labor and related problems at birth, and longitudinal studies reveal that it is linked to some behavioral problems, but little evidence exists that the prenatal drug exposure by *itself* causes children severe and lasting harm. Cocaine exposure in utero, for instance, shows no significant effects on children's physical growth, developmental test scores, or language outcomes.³⁴⁰ Alcohol exposure in utero may be more dangerous than illegal drug exposure.³⁴¹ Rather, the environmental factors of being raised by a parent battling a serious addiction can pose much greater threats, and parental substance abuse is a significant risk factor for abuse or neglect.³⁴² Conversely, effective interventions to provide more positive home environments lead to more positive outcomes for substance-exposed infants.³⁴³ Unfortunately, existing law either treats in utero drug exposure as per se neglect³⁴⁴ or seeks to distinguish babies born with withdrawal symptoms from babies exposed to drugs in utero but with-

339. Clark, *supra* note 333, at 189. *See also id.* ("It appears that many of the mothers who were separated from their young children were unable to concentrate fully on their own recovery and left treatment prematurely."). Similarly, Brenda D. Smith and Mark F. Testa have concluded that "[d]elaying reunification . . . may also exacerbate, in unintended ways, substance abuse and other problems related to future births." Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 CHILD ABUSE & NEGLECT 97, 110 (2002).

340. John P. Ackerman et al., *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 PEDIATRICS 554 (2010), available at <http://pediatrics.aappublications.org/content/128/3/593.2.full.pdf.html>. *See also* Susan Okie, *Encouraging News on Babies Born to Cocaine-Abusing Mothers*, N.Y. TIMES, Feb. 7, 2009, available at <http://www.nytimes.com/2009/01/27/world/americas/27iht-coca.3.19716510.html> (summarizing recent research on the harm of in utero cocaine exposure and the comparative harms of in utero alcohol and tobacco exposure).

341. *Supra* note 334 and accompanying text.

342. *E.g.*, Richard P. Barth, *Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities*, 19 THE FUTURE OF CHILDREN 95, 96 (2009) (listing parental substance abuse as a core risk factor of abuse or neglect and stating that it "is commonly considered to be responsible for a substantial proportion of child maltreatment reported to the child welfare services"); Christine E. Grella et al., *Mothers in Substance Abuse Treatment: Differences in Characteristics Based on Involvement with Child Welfare Services*, 30 CHILD ABUSE & NEGLECT 55, 56 (2006). One study found that parents with a substance-abuse disorder were three times more likely to abuse or neglect their children than those without such a disorder, though the rate was still small—3% in the former group and 1% in the latter. Testa & Smith, *supra* note 336, at 152.

343. SUBSTANCE-EXPOSED INFANTS, *supra* note 336, at 15.

344. *E.g.*, D.C. CODE § 16-2301(9)(A)(vii)-(ix) (2013).

out such symptoms.³⁴⁵ Neither the per se approach nor the withdrawal symptom approach focuses on the core issue of the quality of the environment in which parents raise children.

Although federal law now requires hospital staff to report drug-exposed newborns to CPS authorities,³⁴⁶ this CPS-focused approach has failed to identify the full-range of children and families affected. The federal government estimates that hundreds of thousands of women expose developing fetuses to illegal drugs and significant quantities of alcohol in every trimester of pregnancy³⁴⁷ and that about 400,000 infants are born having been exposed to alcohol or illegal drugs in utero³⁴⁸—compared to a rough estimate of 20,000 CPS calls regarding in utero drug exposure.³⁴⁹ Not only has the CPS-focused approach failed to identify the majority of affected children, this approach may not even direct women with the most severe substance-abuse problems to CPS's attention. A study of mothers in substance abuse treatment in California found that those with child protection system involvement had *less* severe addiction problems than women not involved with CPS.³⁵⁰ Rather than addiction severity, the likelihood of CPS involvement increased with economic stress, having more children (which could exacerbate economic stress), and criminal justice system involvement.³⁵¹ The process of identifying which mothers and substance-exposed children hospital staff report to CPS relates significantly to “race and class bias in hospital policy and practice regarding tests for infant substance exposure.”³⁵² Once CPS learns of substance-exposed infants and their mothers, CPS has not proven par-

345. N.J. Dep't of Children & Families, Div. of Youth and Family Servs. v. A.L., 59 A.3d 576, 588 (N.J. 2013).

346. More precisely, federal law requires states to require hospital staff to do so as a condition of states receiving federal funds. 42 U.S.C. § 5106a(b)(2)(B)(ii) (2010).

347. The government estimates that 286,510 fetuses are exposed to an illegal drug in the first trimester of pregnancy, 130,976 in the second, and 94,139 in the third; 306,975 fetuses are exposed to “binge alcohol” in the first trimester, 106,418 in the second, and 65,488 in the third. Nonbinge alcohol exposure is even wider—843,158 fetuses in the first semester, 417,486 in the second, and 274,231 in the third. SUBSTANCE-EXPOSED INFANTS, *supra* note 336, at 10.

348. *Id.* at 13.

349. SUBSTANCE-EXPOSED INFANTS, *supra* note 336. A similar point can be made about children raised by substance-abusing parents. Prevalence data estimates that there are six to nine million children with a caregiver who abuses a substance—compared with three million CPS allegations and only 900,000 substantiated allegations, including many that have nothing to do with substance abuse. Testa & Smith, *supra* note 336, at 150. The American College of Obstetricians and Gynecologists suggested that screening for substance abuse is significantly lower among women who are not pregnant—including many of these parents. ACOG OPINION 422, *supra* note 197, at 5.

350. Grella et al., *supra* note 342, at 62.

351. *Id.* at 66–67.

352. Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 CHILD ABUSE & NEGLECT

ticularly effective at helping substance-abusing mothers obtain treatment.³⁵³

The solution is not for hospitals to report substance-exposed infants and their mothers to CPS more universally. Voluntary reporting of the most high-risk cases should occur. As argued above, mandatory reporting laws, like the ineffectual federal law requiring hospitals to report, should be reformed.³⁵⁴ The goal, instead, should be to lead drug-abusing pregnant women and mothers³⁵⁵ to obtain the most effective treatment possible, as soon as possible. The threat of mandatory reporting and loss of custody—hallmarks of the present system—operate contrary to that goal.

A public health approach would adopt several other features. First, the medical profession would universally screen pregnant and postpartum women for substance-abuse problems using evidence-based screening tools. One study found that treatment during pregnancy can reduce infant mortality significantly, by 80% in one study, and can reduce preterm and low-birth-weight deliveries by a similar amount.³⁵⁶ Universal screening of pregnant and postpartum women—at least through questionnaires or interviews shown to be effective screening tools³⁵⁷—could go a long way toward filling that gap. It could also reduce the racial and class inequalities that result from the status quo of hospitals and doctors subjectively choosing which women to test for drug and alcohol use.³⁵⁸ Screening for alcoholism among pregnant women is already near-universal, but use of standardized, evidence-based protocols occurs too rarely—the American Congress of Obstetricians and Gynecologists (ACOG) estimates they are only used by 25% of doctors.³⁵⁹ Screening for illegal drug use is lower: more

97, 99 (2002). See Testa & Smith, *supra* note 336, at 159; ACOG OPINION 422, *supra* note 197, at 6–7.

353. Testa & Smith, *supra* note 336, at 154 (“When substance abuse is indicated, evidence also casts doubt that CPS is effective in linking parents to substance abuse services and treatment.”).

354. *Supra*, section II.A and II.C.

355. This Article uses the gendered term “mothers” because of the biological reality that only women’s drug use leads to prenatal drug exposure in infants. Fathers’ drug abuse can lead to harmful neglect just as mothers’ can. But in terms of shaping a public health approach to prenatal drug exposure by hospitals, the biological realities direct a focus on mothers who abuse drugs.

356. Clark, *supra* note 333, at 186–87.

357. SUBSTANCE-EXPOSED INFANTS, *supra* note 336, at 26. See also ACOG OPINION 422, *supra* note 197, at 1 (“As a result of intensive research in addiction over the past decade, evidence-based recommendations have been consolidated into a protocol for universal screening questions, brief intervention, and referral to treatment.”).

358. Barth, *supra* note 114, at 281.

359. ACOG OPINION 422, *supra* note 197, at 6.

than 10% of pregnant women are not screened.³⁶⁰ ACOG has even described expanding such screening as an ethical imperative.³⁶¹

A condition of such wider screening is that the law would need to shield such information from being shared with CPS or law enforcement without the consent of the women tested or a court warrant demanding the results. Broader sharing of such information would likely inhibit disclosure by patients and even screening tests by doctors.³⁶² Such nonconsensual information sharing with entities empowered to impose severe punitive consequences—not the screening itself—has been the crux of Fourth Amendment challenges.³⁶³ Similarly, the law should not define intrauterine substance exposure as a per se form of child abuse or neglect, as several states do.³⁶⁴ There is an insufficient causal link between such exposure and harm,³⁶⁵ and such a definition leads to overly invasive interventions.

Second, doctors and hospitals need to better link pregnant women with treatment services; even when a problem is identified, there is too often a gap between the identification and provision of treatment services.³⁶⁶ State legislators and regulators can assist by more widely imposing treatment standards—such as rules establishing priority for pregnant women who need treatment or requiring interim services if admission to inpatient treatment is not available; such standards exist in twenty-one states and should be more uniform.³⁶⁷ Postpartum women should have the opportunity to seek substance-abuse treatment in facilities in which they can take their newborn children; hospitals should release women and babies directly from the maternity ward to such programs. Such services may be expensive, but their greater effectiveness could save money in the long run.³⁶⁸ Hospitals should employ substance-abuse specialists who can arrange interventions and other tactics designed to induce mothers to enter treatment. At the very least, hospitals can refer families to substance-abuse professionals who can meet the family in the hospital and, if discharged, at home. Such professionals would be in a better position to gauge the severity of risk to an infant at home—whether a mother complies with treatment, whether other adults can adequately take care of the child,

360. *Id.*

361. *Id.*

362. *Id.* at 5–6; Dwyer, *supra* note 198, at 445.

363. *Ferguson v. City of Charleston*, 532 U.S. 67, 84–85 (2001). *See also* Gupta-Kagan, *supra* note 82, at 409 (discussing *Ferguson*).

364. *E.g.*, D.C. CODE § 16-2301(9)(A)(viii) (2013).

365. Testa & Smith, *supra* note 336, at 161.

366. SUBSTANCE-EXPOSED INFANTS, *supra* note 336, at 27.

367. *Id.* at 29.

368. Every dollar spent on treatment can, according to some studies, save up to \$7 in costs associated with ongoing addiction. ACOG OPINION 422, *supra* note 197, at 2.

and whether a parent's drug use is a debilitating addiction or less unhealthy recreation. Such professionals could call CPS when the child appears at risk.

Third, after children are born exposed to substances, the law needs to develop more effective ways to link substance-exposed children to developmental services. The law currently requires child welfare agencies to refer young children for early childhood interventions only if the child is the subject of a substantiated case of child abuse or neglect.³⁶⁹ There is no good reason to condition service referrals on CPS involvement and substantiation.³⁷⁰ Rather than require such referrals of CPS agencies in limited circumstances, the law should require doctors and hospital staff to make early childhood developmental and education referrals directly without using CPS as a middleman.³⁷¹

None of these ideas suggest that CPS has no role—only that its role should be focused on cases presenting some risk of harm beyond substance abuse itself or on cases for which less coercive treatment options have failed. Similarly, when doctors and hospital staff encounter pregnant and postpartum women with substance-abuse problems, their first call should be to help such women enter treatment, not to CPS. A call to CPS may come—and, for a large number of children, will and should come—but it should not be the first call.

These proposals will surely be controversial, as many may be suspicious of an approach built around voluntary treatment efforts. Others have argued forcefully for more aggressive and coercive action by CPS to protect children of substance-abusing parents.³⁷² The proposals discussed in this Article, however, would not exclude CPS actions. They would build a stronger infrastructure of voluntary services, including a set of individuals who can effectively identify those children most at risk of abuse or neglect.³⁷³ Such steps would ensure CPS authorities become aware of more of those children than under the present system. For these children, the failure of prior efforts would surely be, and should be, relevant to CPS's decision-making. Accordingly, the proposals outlined in this section could increase both the number of families who receive voluntary treatment for substance abuse without separating the family, as well as the number of infants of substance-abusing parents who are brought to CPS's attention for coercive government action.

369. 42 U.S.C. § 5106a(b)(2)(B)(xxi) (2010).

370. *Supra* Part V.

371. This requirement could be met by a call to a substance-abuse disorder hotline, which could then make various referrals.

372. *E.g.*, ELIZABETH BARTHOLET, *NOBODY'S CHILDREN: ABUSE AND NEGLECT, FOSTER DRIVE, AND THE ADOPTION ALTERNATIVE* 207–32 (1999); Dwyer, *supra* note 198, at 449–51.

373. For one possible example of such a case, see *supra* note 37 and accompanying text.

VIII. CONCLUSION

Virtually everyone familiar with the child welfare system agrees that it needs significant improvement. A public health model would enable society to respond to the millions of children facing mild harms more effectively and would enable child protection authorities to respond to the more serious cases more effectively. This Article identifies the legal reforms necessary to create a public health model. Policymakers should reform elements of the current system that impede a public health approach and build new laws to catalyze development of such an approach.

A public health approach is desirable for multiple reasons. It would offer a range of interventions that match the range of conditions that families face, rather than impose a coercive approach on an overly wide range of families. These reforms would also expand more voluntary means of providing secondary and tertiary prevention services to families—both by narrowing the scope of coercive interventions and building a legal structure for more voluntary interventions to troubled families. Thus, it better respects the constitutional values of family integrity by avoiding coercive approaches when voluntary approaches may work. These reforms would simultaneously focus such coercive interventions on the most severe cases, thus helping agencies more effectively protect children from the most severe forms of abuse. A public health approach would create clearer and more consistent standards for intervention and thus foster a baseline for the development of crucial tools for more statistically grounded decisions.

This Article identifies essential elements of such reforms. It is a beginning step toward a comprehensive legal infrastructure. The value of a public health approach should spark further efforts to identify necessary reforms and, more broadly, the social science work necessary to develop widely available and high-quality services that can rest on that infrastructure.